

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G253 12/3/59 iwk

12180

12212

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville 52</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>at home - 51 Wade Ave. Catonsville Md. 28,</i>		d. STREET ADDRESS <i>Wade Ave Ave "Store"</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Frank H. Alban</i>		4. DATE OF DEATH Month <i>11</i> Day <i>24</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/5/199</i>
9. AGE (In years last birthday) <i>60</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Grocery store owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Md</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Harry A. Alban</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Gordon</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Geo. F. Alban</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Coronary Thrombosis</i> DUE TO (b) <i>Hypertensive C.V. Disease</i> DUE TO (c) <i>1 hr</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11-13</i> , 19 <i>59</i> , to <i>11-24</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>11-23</i> , 19 <i>59</i> , and that death occurred at <i>3 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James B. Howell</i>		ADDRESS (Street, city or town, state) <i>Catonsville</i> DATE SIGNED <i>11-25</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/27/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>		22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Macmillan & Son 28</i>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <i>NOV 30 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Cuthbert L. Kneass</i>	

51551

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12213

CERTIFICATE OF DEATH

Reg. Dist. No.

12181

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.-</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rayville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>B.</u> Last <u>Almony</u>		4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar Tender.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Top Room</u>	
11. BIRTHPLACE (State or foreign country) <u>White Hall, Md.-</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Benjamin Almony</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Rosier.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>213-28-1758</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous cell carcinoma with metastases</u> DUE TO (b) <u>191.9</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>4 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 25, 1959</u> to <u>11-7-1959</u> , that I last saw the deceased alive on <u>11-7-1959</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Robinson,</u>		ADDRESS (Street, city or town, state) <u>New Freedom, Pa.</u> DATE SIGNED <u>11-14-59</u>	
PHYSICIAN'S NAME (Type) <u>R. ROBINSON</u>		<u>New Freedom, Pa.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial.</u>		22b. DATE THEREOF <u>11/15/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stablersville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Parkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Fortenstein,</u>		24a. REC'D BY REGISTRAR <u>Carbur & Kinn</u>	
ADDRESS <u>New Freedom, Pa.</u>		DATE <u>NOV 17 '59</u>	

13181

CERTIFICATE OF DEATH

13181

[Faint, illegible text, likely bleed-through from the reverse side of the document. The text appears to be a form with various fields and lines.]

12214

CERTIFICATE OF DEATH

Reg. Dist. No.

12182

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRADSHAW c. LENGTH OF STAY IN 1b BRADSHAW d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHEFFERS ROAD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRADSHAW d. STREET ADDRESS PHEFFERS ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Henry Appel First Middle Last 4. DATE OF DEATH Nov. 6 1959 Month Day Year		5. SEX male 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH SEPT 12, 1892 9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PFEIFFER RETIRED 10b. KIND OF BUSINESS OR INDUSTRY ARSENAL 11. BIRTHPLACE (State or foreign country) BALTO CO. MD. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN H. APPEL 14. MOTHER'S MAIDEN NAME EMMA HITCHCOCK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES 16. SOCIAL SECURITY NO. 22042357437 17. INFORMANT JOHN H APPEL RFD 3 BELAIR ACRES. Address BELAIR MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour Month Day Year p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from Nov. 6, 1959 , to Nov. 6, 1959 , that I last saw the deceased alive on Nov. 6, 1959 , and that death occurred at 8 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED William A. Tyson M.D. Kingsville, Md. 11-6-59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) William A. Tyson			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 11-9-59 22c. NAME OF CEMETERY OR CREMATORY FORK METHODIST 22d. LOCATION (City, town, or county) (State) FORK MD.		23. FUNERAL DIRECTOR'S SIGNATURE Sassahn Funeral Home ADDRESS 7401 Belair Road 24a. REC'D BY REGISTRAR DATE NOV 12 '59 24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

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BALTIMORE, MARYLAND

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 6 Film G252 11-16-59 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Winter an Extended		d. STREET ADDRESS 467 Commonwealth Ave	
3. NAME OF DECEASED (Type or print) Alice Elizabeth Bacon		4. DATE OF DEATH Nov 5 1959	
5. SEX F	6. COLOR OR RACE Col W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 6 1924
9. AGE (In years last birthday) 35 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Colored	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Remus Bacon		14. MOTHER'S MAIDEN NAME Lena Crawford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Remus Bacon		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Geo. W. Kieffer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) GEO. S. M. KIEFFER		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Nov 6, 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-8-59	
22c. NAME OF CEMETERY OR CREMATORY Western Star Cem.		22d. LOCATION (City, town, or county) (State) Catonsville MD	
23. FUNERAL DIRECTOR'S SIGNATURE G. Halstead ADDRESS 918 Druid Hill Ave.		24a. REC'D BY REGISTRAR DATE NOV 9 '59	
		24b. REGISTRAR'S SIGNATURE Arthur J. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12216

CERTIFICATE OF DEATH

Reg. Dist. No.

12184

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOCHARN MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO. MD</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AUGSBURG Home</u>		d. STREET ADDRESS <u>42 S. Pulaski</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUISE ASENDORF BAUSMAN</u>		4. DATE OF DEATH Month Day Year <u>NOV. 4, 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/21/1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Albert T. ASENDORF</u>		14. MOTHER'S MAIDEN NAME <u>Thiemeyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Records AUGSBURG Home</u>		Address <u>6811 CAMPFIELD RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>(2) Hypertensive Heart Disease</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 10, 1958</u> , to <u>Nov. 4, 1959</u> , that I last saw the deceased alive on <u>Nov. 4, 1959</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl L. Chambers</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4108 Liberty Hts. Ave. Balto. Md. 11-6-59</u>	
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>		<u>4108 Liberty Hts. Ave. Balto. Md. —</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF	
<u>BURIAL</u>		<u>NOV. 6 59</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>LODON PK</u>		<u>BALTO.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>P. A. Heemann</u>		<u>6067 Harford Rd.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>NOV 9 '59</u>		<u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

12318

1. NAME OF DECEASED JAMES H. SMITH		2. SEX Male		3. AGE 65	
4. DATE OF DEATH Jan 15, 1912		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. DISEASE OR INJURY Coronary Artery Disease		9. MANNER OF DEATH Natural	
10. SIGNATURE OF PHYSICIAN J. H. Smith		11. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith		12. SIGNATURE OF REGISTRAR J. H. Smith	
13. PLACE OF BIRTH Maryland		14. DATE OF BIRTH Jan 1, 1847		15. OCCUPATION Farmer	
16. MARITAL STATUS Married		17. EDUCATION High School		18. RELIGION Roman Catholic	
19. PREVIOUS ILLNESS None		20. PREVIOUS SURGERY None		21. PREVIOUS TRAUMA None	
22. PREVIOUS ALCOHOLIC DRINKING None		23. PREVIOUS TOBACCO SMOKING None		24. PREVIOUS DRUG USE None	
25. PREVIOUS RHEUMATISM None		26. PREVIOUS GOUT None		27. PREVIOUS DIABETES None	
28. PREVIOUS HYPERTENSION None		29. PREVIOUS BRONCHITIS None		30. PREVIOUS PNEUMONIA None	
31. PREVIOUS TUBERCULOSIS None		32. PREVIOUS MALARIA None		33. PREVIOUS SYPHILIS None	
34. PREVIOUS SCURVY None		35. PREVIOUS RICKETS None		36. PREVIOUS ANEMIA None	
37. PREVIOUS LEUKEMIA None		38. PREVIOUS LYMPHOMA None		39. PREVIOUS SARCOMA None	
40. PREVIOUS CARCINOMA None		41. PREVIOUS MELANOMA None		42. PREVIOUS OSTEOID OSTOMA None	
43. PREVIOUS OSTEOBLASTOMA None		44. PREVIOUS OSTEOGENESIS IMPERFECTA None		45. PREVIOUS PAGET-BRISTOL DISEASE None	
46. PREVIOUS HYPEROSTOTIC BONE DISEASE None		47. PREVIOUS OSTEOPOROSIS None		48. PREVIOUS OSTEOMYELITIS None	
49. PREVIOUS OSTEOMA None		50. PREVIOUS OSTEOPETRIOSIS None		51. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None	
52. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		53. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		54. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None	
55. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		56. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		57. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None	
58. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		59. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		60. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None	
61. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		62. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		63. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None	
64. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		65. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		66. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None	
67. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		68. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		69. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None	
70. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		71. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		72. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None	
73. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		74. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		75. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None	
76. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		77. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		78. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None	
79. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		80. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		81. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None	
82. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		83. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		84. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None	
85. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		86. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		87. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None	
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91. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		92. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		93. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None	
94. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		95. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		96. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None	
97. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		98. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		99. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None	
100. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		101. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None		102. PREVIOUS OSTEOPETROGENESIS IMPERFECTA None	

1. NAME OF DECEASED
JAMES H. SMITH

2. SEX
Male

3. AGE
65

4. DATE OF DEATH
Jan 15, 1912

5. TIME OF DEATH
10:30 AM

6. PLACE OF DEATH
Home

7. CAUSE OF DEATH
Heart Disease

8. DISEASE OR INJURY
Coronary Artery Disease

9. MANNER OF DEATH
Natural

10. SIGNATURE OF PHYSICIAN
J. H. Smith

11. SIGNATURE OF WITNESSES
J. H. Smith, J. H. Smith

12. SIGNATURE OF REGISTRAR
J. H. Smith

13. PLACE OF BIRTH
Maryland

14. DATE OF BIRTH
Jan 1, 1847

15. OCCUPATION
Farmer

16. MARITAL STATUS
Married

17. EDUCATION
High School

18. RELIGION
Roman Catholic

19. PREVIOUS ILLNESS
None

20. PREVIOUS SURGERY
None

21. PREVIOUS TRAUMA
None

22. PREVIOUS ALCOHOLIC DRINKING
None

23. PREVIOUS TOBACCO SMOKING
None

24. PREVIOUS DRUG USE
None

25. PREVIOUS RHEUMATISM
None

26. PREVIOUS GOUT
None

27. PREVIOUS DIABETES
None

28. PREVIOUS HYPERTENSION
None

29. PREVIOUS BRONCHITIS
None

30. PREVIOUS PNEUMONIA
None

31. PREVIOUS TUBERCULOSIS
None

32. PREVIOUS MALARIA
None

33. PREVIOUS SYPHILIS
None

34. PREVIOUS SCURVY
None

35. PREVIOUS RICKETS
None

36. PREVIOUS ANEMIA
None

37. PREVIOUS LEUKEMIA
None

38. PREVIOUS LYMPHOMA
None

39. PREVIOUS SARCOMA
None

40. PREVIOUS CARCINOMA
None

41. PREVIOUS MELANOMA
None

42. PREVIOUS OSTEOID OSTOMA
None

43. PREVIOUS OSTEOBLASTOMA
None

44. PREVIOUS OSTEOGENESIS IMPERFECTA
None

45. PREVIOUS PAGET-BRISTOL DISEASE
None

46. PREVIOUS HYPEROSTOTIC BONE DISEASE
None

47. PREVIOUS OSTEOPOROSIS
None

48. PREVIOUS OSTEOMYELITIS
None

49. PREVIOUS OSTEOMA
None

50. PREVIOUS OSTEOPETRIOSIS
None

51. PREVIOUS OSTEOPETROGENESIS IMPERFECTA
None

52. PREVIOUS OSTEOPETROGENESIS IMPERFECTA
None

53. PREVIOUS OSTEOPETROGENESIS IMPERFECTA
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54. PREVIOUS OSTEOPETROGENESIS IMPERFECTA
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55. PREVIOUS OSTEOPETROGENESIS IMPERFECTA
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56. PREVIOUS OSTEOPETROGENESIS IMPERFECTA
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99. PREVIOUS OSTEOPETROGENESIS IMPERFECTA
None

100. PREVIOUS OSTEOPETROGENESIS IMPERFECTA
None

101. PREVIOUS OSTEOPETROGENESIS IMPERFECTA
None

102. PREVIOUS OSTEOPETROGENESIS IMPERFECTA
None

CERTIFICATE OF DEATH

Reg. Dist. No.

12217

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 79 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle B. H. Last BECK				4. DATE OF DEATH Month NOVEMBER Day 22 Year 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH OCTOBER 11, 1919	
9. AGE (In years lost birthday) yrs. 40		IF UNDER 1 YEAR Months 26 Days 03 Hours 00 Min. 00		IF UNDER 24 HRS. Hours 00 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE AGENT				10b. KIND OF BUSINESS OR INDUSTRY INSURANCE AGENCY		11. BIRTHPLACE (State or foreign country) UTAH	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HARRY M. BECK				14. MOTHER'S MAIDEN NAME ELOISE MC BRINE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES WW-11				16. SOCIAL SECURITY NO. CLIN REC VAH BALTO MD FT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 591X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) NEPHRITIS, SUBACUTE DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Edema of lungs and brain. INTERVAL BETWEEN ONSET AND DEATH 2603 Days 8 Months							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from September 4, 1959 to November 22, 1959 and that death occurred at 1:10 p.m. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTIMORE 18, MD. FT. HOWARD, MD. 11/23/59							
ACTUAL SIGNATURE John W. Crawford M.D. VAH, BALTIMORE 18, MD. FT. HOWARD, MD.							
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. VAH, BALTIMORE 18, MD. FT. HOWARD, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 11-25-59			
22c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY				22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE WM COOK-BLIGHT INC ADDRESS 6009 Harford Road Baltimore Md							
24a. REC'D BY REGISTRAR NOV 27 59 DATE							
24b. REGISTRAR'S SIGNATURE W. R. H. H. H.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK

1881

11

IN SENATE

January 1, 1881

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION

PASSED BY THE SENATE, APRIL 1, 1879

ALBANY:

1881

1881

1881

PRINTED BY THE

SENATE

1881

ALBANY: 1881

1881

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1881

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12186

12218

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Baltimore (4)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1604 Thetford Rd.</u>		d. STREET ADDRESS <u>1604 Thetford Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Mildred</u> Last <u>Bergmann</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>19 59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.	11. IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Schaefer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Toufel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mrs Wm. F. Church</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary Sclerosis & Insufficiency</u> (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Instant</u> Interval between onset and death <u>5 yrs</u> <u>10 yrs</u>		18. INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-10-1951</u> , to <u>11-9-1959</u> that I last saw the deceased alive on <u>11-9-1959</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert H. Giver</u>		DATE SIGNED <u>11-9-59</u>	
PHYSICIAN'S NAME (Type) <u>R. H. Giver</u>		ADDRESS (Street, city or town, state) <u>3105 N. Charles St. Baltimore, 18. Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/11/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR <u>NOV 12 '59</u>	
ADDRESS <u>5305 Harford Rd</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

VS A15 (4)
15M 9/58

1218

CERTIFICATE OF DEATH

1218

Deceased

Age

Sex

Place of Birth

Residence

Occupation

Married () Single () Widowed () Divorced ()

Date of Birth

19-11-1901

Place of Birth

121

Occupation

Residence

Married () Single ()

Place of Birth

Age

Date of Birth

Signature of Registrar

Signature of Deceased

Signature of Witness

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12219

CERTIFICATE OF DEATH

12187

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto. Co.</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i> c. LENGTH OF STAY IN 1b <i>52</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Grady North Home</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i> d. STREET ADDRESS <i>6608 Greenock St.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ELIZABETH C. BERLAU</i> First Middle Last 5. SEX <i>Female</i> 6. COLOR OR RACE <i>White</i> 7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>10/1/69</i> 9. AGE (In years last birthday) <i>90</i> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.		4. DATE OF DEATH <i>Nov. 30 1959</i> Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i> 11. BIRTHPLACE (State or foreign country) <i>Md.</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Conrad Beyer</i> 14. MOTHER'S MAIDEN NAME <i>Wilhemina</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> 16. SOCIAL SECURITY NO. <i>154X</i> INFORMANT <i>Esther Brady</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMA OF RECTUM METASTASIS TO LYMPHGLANDS</i> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>13 mos.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>ARTERIO SCLEROSIS; ARTERIOSCLEROTIC HEART DIS; PHLEBITIS</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>APR. 24</i> , 1958, to <i>NOV 30</i> , 1959, that I last saw the deceased alive on <i>NOV. 29</i> , 1959, and that death occurred at <i>2:10 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>6348 FREDERICK RD BALTIMORE 28, MD.</i> DATE SIGNED <i>12/1/59</i> ACTUAL SIGNATURE <i>John N. Snyder</i> M.D. PHYSICIAN'S NAME (Type) <i>JOHN N. SNYDER, M.D., BALTIMORE 28, MD.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>12/3/59</i> 22c. NAME OF CEMETERY OR CREMATORY <i>St. Matthews</i> 22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Macdunn + son</i> ADDRESS <i>28</i> 24a. REC'D BY REGISTRAR <i>DEC 3 '59</i> DATE 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

CERTIFICATE OF DEATH

1921



STATE OF NEW YORK
DEPARTMENT OF HEALTH
OFFICE OF THE REGISTRAR OF DEATHS



NEW YORK

1921

1921

1921

1921

1921

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12188

12220

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe 51</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgway Manor</u>		d. STREET ADDRESS <u>5712 First Ave.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Eda V.</u> Middle <u>Bowen</u> Last		4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1888</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>210-22-9576A</u>		17. INFORMANT Address <u>Thomas Carlin 5708 First Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>March 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 10</u> , 19 <u>59</u> , and that death occurred at <u>2:30 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. Bradley Longharity</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>17647 Morris Ave. Balt 29th Mar 1959</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrose, Inc. 1324 Sulfur Spring Rd</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 25 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

98181

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12195

CERTIFICATE OF DEATH

12189

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1924 Maxwell Avenue				d. STREET ADDRESS 1924 Maxwell Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANCES Middle M. Last BRANDT				4. DATE OF DEATH Month November Day 29 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1912		9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Piechocki				14. MOTHER'S MAIDEN NAME Pelagia Swieczikowska			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212071064		17. INFORMANT Address Mr. T. Piechocki, 1924 Maxwell Ave 22			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Crisis - Vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-12 , 19 56 to July 7 , 19 59 that I last saw the deceased alive on July 7 , 19 59 , and that death occurred at 4 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1801 ELEANOR PL. BALTO 17, MD DATE SIGNED 11/30/59 ACTUAL SIGNATURE Lester Lebo M.D. PHYSICIAN'S NAME (Type) LESTER LEBO							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/2/59		22c. NAME OF CEMETERY OR CREMATORY Holy Rosary		22d. LOCATION (Street, city or town, county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. F. SADOWSKI & SONS, 1808 EASTERN AVENUE Charles D. Sadowski				24a. REC'D BY REGISTRAR DATE DEC 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12190

12221

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
c. LENGTH OF STAY IN lb 14 MONTHS 10 DAYS		d. STREET ADDRESS 16 MADELENE AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANK Middle BRANDT Last BRANDT		4. DATE OF DEATH Month NOV Day 4 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-2-1870
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 8 Days 10 Hours 10 Min.	11. IF UNDER 24 HRS. Months 8 Days 10 Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) BALTO., CO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CARL BRANDT		14. MOTHER'S MAIDEN NAME CAROLINE HAGEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT BRANDT MILLER		Address 3306 FOSTER AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE - CIRCULATORY COLLAPSE 422.1 DUE TO SENILITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CIRCULATORY COLLAPSE (c) SENILITY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 11 p. m. 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/1 , 19 59 , to 11/4 , 19 59 , that I last saw the deceased alive on 11/4 , 19 59 , and that death occurred at 4 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5800 EDMONDSON AVE BALTO., MD. DATE SIGNED 11/4/59			
ACTUAL SIGNATURE John H. Shaw M.D.		PHYSICIAN'S NAME (Type) JOHN H. SHAW MD BALTO., MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-7-59	
22c. NAME OF CEMETERY OR CREMATORY MT. CARMEL CEM.		22d. LOCATION (City, town, or county) (State) BALTO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Funeral Home of Baltimore, Md. ADDRESS NOV 12 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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121100

CENTRAL OFFICE

12324

Return to the
Director of the
Department of Revenue
Boston, Massachusetts

Enclosed for the
Director of the
Department of Revenue
are the following

1. Report of the
Director of the
Department of Revenue
for the year 1911

2. Report of the
Director of the
Department of Revenue
for the year 1912

3. Report of the
Director of the
Department of Revenue
for the year 1913

4. Report of the
Director of the
Department of Revenue
for the year 1914

5. Report of the
Director of the
Department of Revenue
for the year 1915

6. Report of the
Director of the
Department of Revenue
for the year 1916

7. Report of the
Director of the
Department of Revenue
for the year 1917

8. Report of the
Director of the
Department of Revenue
for the year 1918

9. Report of the
Director of the
Department of Revenue
for the year 1919

10. Report of the
Director of the
Department of Revenue
for the year 1920

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12191

12222

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. Howard c. LENGTH OF STAY IN lb 15 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 3V01-4 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2806 Winchester Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALEXANDER Middle ----- Last BRIGHT, JR.		4. DATE OF DEATH Month November Day 29 Year 19 59			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1917	9. AGE (In years lost birthday) 42 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10b. KIND OF BUSINESS OR INDUSTRY Shipping		11. BIRTHPLACE (State or foreign country) Camden, North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Alexander		14. MOTHER'S MAIDEN NAME Amelia Tillit	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 231-09-1524		INFORMANT Clin. Rec. VAH Balto. 18, Md., Ft. Howard Div.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157x INANITION DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) ADENOCARCINOMA OF PANCREAS WITH METASTASIS DUE TO (c) UNKNOWN		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 14, 1959 to November 29, 1959 , and that death occurred at 4:20AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Balto., Md., Ft. Howard Division DATE SIGNED 11/29/59					
ACTUAL SIGNATURE Walter C. Goldstein, M.D.		M.D. VAH Balto., Md., Ft. Howard Division 11/29/59			
PHYSICIAN'S NAME (Type) WALTER C. GOLDSTEIN, MD		VAH Balto., Md., Ft. Howard Division 11/29/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 6, 1959		22c. NAME OF CEMETERY OR CREMATORY Shiloh Cemetery	
22d. LOCATION (City, town, or county) (State) Camden, North Carolina		24a. REC'D BY REGISTRAR DEC 1 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kears	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph L. Russ ADDRESS 2222 W. North Ave. Balto., Md.					

JOSEPH L. RUSS FUNERAL HOME, 2222 W. NORTH AVE., BALTO., MD.

CERTIFICATE OF DEATH

12345

12345

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12223

CERTIFICATE OF DEATH

12192

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN lb 26 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Greens Lane		d. STREET ADDRESS Winans Road	
3. NAME OF DECEASED (Type or print) Katherine A. Brodbeck		4. DATE OF DEATH Nov. 18, 1959	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> Yes	8. DATE OF BIRTH April 1, 1881
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Moses Buffensperger		14. MOTHER'S MAIDEN NAME Susan Bankert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. George R. Brodbeck		Address Winans Road Box 556	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary sclerosis (c) Arth. Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 months 2 yrs. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1949 to November 18, 1959 , that I last saw the deceased alive on November 16, 1959 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James A. Miller M.D.		ADDRESS (Street, city or town, state) Reisterstown Rd & Walker Ave. Pikeville, Md.	
PHYSICIAN'S NAME (Type) James A. Miller M.D.		DATE SIGNED 10/19/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/21/59	
22c. NAME OF CEMETERY OR CREMATORY Stone Church Cemetery		22d. LOCATION (City, town, or county) (State) Brodbeck, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		ADDRESS 8728 Liberty Road	
24a. REC'D BY REGISTRAR NOV 23 59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	
DATE NOV 23 59			

Randallstown, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12193

Reg. Dist. No.

12224

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1200 Tugwell ROAD Dr.		d. STREET ADDRESS 1200 Tugwell ROAD Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Fannie F. Brooks		4. DATE OF DEATH Month Day Year Nov. 21, 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1878
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert J. Price		14. MOTHER'S MAIDEN NAME Sallie Mongen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Philip D. Brooks		Address 1200 Tugwell ROAD Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 18, 1958 to Nov. 21, 1959 that I lost saw the deceased alive on Nov. 18, 1959 , and that death occurred at 7:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE Leo J. Gaver M.D.			
PHYSICIAN'S NAME (Type) XX Leo Gaver, M.D.		1 Mallow Hill Rd.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11:24:59	22c. NAME OF CEMETERY OR CREMATORY Louden Park Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		24a. REC'D BY REGISTRAR DATE NOV 24 '59	
ADDRESS 4107 Wilkens Ave.		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12225

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

VS A15 (4)
ISM 9/58

1. PLACE OF DEATH o. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 57 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 3207 Hilltop Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN		Middle J.		Last BROOKS		4. DATE OF DEATH Month November	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25, 1874	
9. AGE (In years lost birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cloth Folder		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN BROOKS				14. MOTHER'S MAIDEN NAME MARY GLYNN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 029-03-4232		INFORMANT CLIN.REC.VET.ADM.HOSP.BALTO.MD.FT.HOWARD DIV			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO-PNEUMONIA 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 4 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) STATUS POST PROSTATECTOMY FOR BHP. GENERALIZED ARTERIOSCLEROSIS						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		20g. (City or town) _____ (County) _____ (State) _____		20h. (City or town) _____ (County) _____ (State) _____	
21. I certify that VA attended the deceased from September 21, 1959 , to November 17, 1959 , and that death occurred at 1:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Norris L. Newton M.D. M.D. VET.ADM.HOSP.BALTO.MD.FT HOWARD DIV 11/17/59 PHYSICIAN'S NAME (Type) NORRIS L. NEWTON, M.D. VA HOSPITAL, BALTO, MD. FT. HOWARD DIV.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11-18-59		22c. NAME OF CEMETERY OR CREMATORY St. Patrick's		22d. LOCATION (City, town, or county) (State) Fall River, Massachusetts	
23. FUNERAL DIRECTOR'S SIGNATURE Donnelly Funeral Home, S. Main Street, Fall River, Massachusetts				24a. REC'D BY REGISTRAR NOV 19 1959		24b. REGISTRAR'S SIGNATURE Arthur S. French	

Wm Cook, Inc, 1217 St Paul St

2001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12195

12226

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN 1b 52 CATONSVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOUSE IN THE PINES				d. STREET ADDRESS 15 ARTHUR AVE.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Bertha E Brown				4. DATE OF DEATH Month Day Year 11 11 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 1, 1878	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME SAMUEL KEEN				14. MOTHER'S MAIDEN NAME KEZIAH KNIGHT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. B 220-05-5061		17. INFORMANT Address MR. JOHN H. BROWN 5 ARTHUR AVE. CATONSVILLE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 442 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) Hypertensive Cardio-Vascular-Renal Disease INTERVAL BETWEEN ONSET AND DEATH 9 da. 10 yr. 15 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2-6-1956 , to 11-11-1959 , that I last saw the deceased alive on 11-11-1959 , and that death occurred at 7:50 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6209 Frederick Ave. 11-11-59 ACTUAL SIGNATURE Wilmer K. Gallagher M.D. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher Baltimore-28, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-14-1959		22c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEM. WOODLAWN, MD.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Easton's Sons CATONSVILLE, MD.				24a. REC'D BY REGISTRAR DATE NOV 16 59		24b. REGISTRAR'S SIGNATURE Robert A. Wright	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12196

Reg. Dist. No.

12227

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown			c. LENGTH OF STAY IN 1b 35 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 17 Dean Avenue				d. STREET ADDRESS 17 Dean Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Slade Last Brown				4. DATE OF DEATH Month November Day 4 Year 1959			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 2 1887	
9. AGE (In years by birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Church Janitor				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Franklin Brown				14. MOTHER'S MAIDEN NAME Alice Flater			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Elmer Randall Reisterstown Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the lung, rt. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral inguinal hernias, Bilateral blindness						INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. none		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 9-30-53 , 19____, to 11-4-59 , 19____, that I last saw the deceased alive on 11-4-59 , 19____, and that death occurred at 7 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE A. D. Caples M.D. 6 Hanover Rd. 11-6-59 PHYSICIAN'S NAME (Type) D. D. Caples, M. D. Reisterstown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 7 1959		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove		22d. LOCATION (City, town, or county) (State) Sandy Mount Carroll Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. B. Everyman & Sons				ADDRESS Reisterstown		24a. REC'D BY REGISTRAR DATE Nov 9 '59	
				24b. REGISTRAR'S SIGNATURE Clifton S. House			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NAME OF DECEASED [REDACTED]		SEX [REDACTED]	
AGE [REDACTED]		DATE OF BIRTH [REDACTED]	
PLACE OF BIRTH [REDACTED]		COUNTY [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]	
MANNER OF DEATH [REDACTED]		MEDICAL ATTENDANT [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
PLACE OF DEATH [REDACTED]		CITY [REDACTED]	
STATE [REDACTED]		COUNTY [REDACTED]	
ZIP CODE [REDACTED]		SIGNATURE OF DECEASED [REDACTED]	
SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF MEDICAL ATTENDANT [REDACTED]	
SIGNATURE OF REGISTRAR [REDACTED]		SIGNATURE OF CLERK [REDACTED]	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING AND INDEXING.

FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, ON [REDACTED] AT [REDACTED] O'CLOCK [REDACTED] P.M.

FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, ON [REDACTED] AT [REDACTED] O'CLOCK [REDACTED] P.M.

12228

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - RUXTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - RUXTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1404 Maywood Avenue		d. STREET ADDRESS 1404 MAYWOOD AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HOWARD Middle L. Last BROWN		4. DATE OF DEATH Month NOV Day 15 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1892
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stonewall Jackson Brown		14. MOTHER'S MAIDEN NAME Maggie A. Massey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Mrs. Lillian M. Brown, 1404 Maywood Avenue	
17. INFORMANT Mrs. Lillian M. Brown, 1404 Maywood Avenue		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANGIO SARCOMA OF GREATER OMENTUM 158X DUE TO WITH METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 5 MOS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE 19, 1959 , to NOV 15, 1959 , that I last saw the deceased alive on 11-15, 1959 , and that death occurred at 9:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Luther E. Little		ADDRESS (Street, city or town, state) 10 W. Madison St	
DATE SIGNED			
PHYSICIAN'S NAME (Type) LUTHER E. LITTLE			
22a. BURIAL, CREMATION, (Specify) BURIAL		22b. DATE THEREOF 11-18-59	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road, Zone 4		ADDRESS	
24a. REC'D BY REGISTRAR NOV 19 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

Case No. 11

Name of Deceased		John F. Smith	
Age		45	
Sex		Male	
Race		White	
Marital Status		Married	
Occupation		Teacher	
Cause of Death		Heart Disease	
Date of Death		March 15, 1922	
Place of Death		Home	
Physician		Dr. J. H. Jones	
Burial Place		St. John's Church	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		March 16, 1922	
Registrar's Office		Baltimore, Md.	

12229

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville	
		f. STREET ADDRESS none	
3. NAME OF DECEASED (Type or print) First Middle Last Edmund Thompson Bryan		4. DATE OF DEATH Month Day Year 11-11-59 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-8-1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief plumbing insp.		10b. KIND OF BUSINESS OR INDUSTRY BALTO. CO.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edmund Bryan		14. MOTHER'S MAIDEN NAME Anna Ambrose	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-32-0310	
17. INFORMANT Sanders K. Bryan		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardin Vascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 6 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 10 , 19 59 , to Nov. 11 , 19 59 , that I lost saw the deceased alive on Nov. 10 , 19 59 , and that death occurred at 12 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE A. M. France		ADDRESS (Street, city or town, state) Parkton, Md.	
PHYSICIAN'S NAME (Type) A. M. FRANCE		DATE SIGNED 11/12/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-14-59	22c. NAME OF CEMETERY OR CREMATORY Parkwood	22d. LOCATION (City, town, or county) (State) Baltimore 14, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.		24a. REC'D BY REGISTRAR DATE NOV 16 '59	24b. REGISTRAR'S SIGNATURE Arthur & France

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1932

1932

Name of Deceased		Township	
John Doe		Brookfield	
Age		Sex	
45		Male	
Date of Birth		Date of Death	
11-11-86		11-11-32	
Place of Birth		Cause of Death	
Chicago, Ill.		Heart Disease	
Occupation		Burial Place	
Farmer		Brookfield Cemetery	
Signature of Minister		Signature of Registrar	
[Signature]		[Signature]	
Date		Time	
11-11-32		10:00 AM	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN 1b 2 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				d. STREET ADDRESS 3974 DOFFIELD AVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last LILLIE MAY BURDETTE				4. DATE OF DEATH Month Day Year NOV 24 1959			
5. SEX FE		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-22-1869	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME JOHN W. PERKINSON				14. MOTHER'S MAIDEN NAME GEORGIANNA BURDETTE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Frank L. Smith Jr. - Cockeysville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While o. m. p. m. of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore, Md.				20g. (County) Baltimore			
20h. (State) Md.							
21. I certify that I attended the deceased from 12-9 , 19 57 , to 11-23 , 19 59 , that I last saw the deceased alive on 11-23 , 19 59 , and that death occurred at 3:21 P.M. , from the causes and on the date stated above. Signature Frank L. Smith Jr. ADDRESS (Street, city or town, state) Cockeysville, Md. DATE SIGNED 11/24/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF Nov. 27, 1959		22c. NAME OF CEMETERY OR CREMATORY Lorraine		22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Cook, Inc. 1217 St. Paul St.				24a. REC'D BY REGISTRAR DATE NOV 27 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12200

Reg. Dist. No.

12231

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yr10mth5days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 17, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 3739 Oak Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bessie Middle Davis Last Bennett Cain				4. DATE OF DEATH Month November Day 27 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1875		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Purnell Bennett				14. MOTHER'S MAIDEN NAME Hester Anne Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. none		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular accident DUE TO (c) Cerebral and generalized arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. fell from chair to floor on 9-9-59 sustaining sub-capital frac. of left femur					
20c. TIME OF INJURY Hour 8:00 a. m. PM Month, Day, Year 9-9 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) (County) (State) Catonsville 28, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George M. Kieffer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/30/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Meth. Ch. Cem.		22d. LOCATION (City, town, or county) (State) Fountain Green, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Am. J. Sicker				ADDRESS 404 S. Baltimore		24a. REC'D BY REGISTRAR DATE NOV 30 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. House	

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

105

1

INSTRUCTIONS

1 **M**

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12201

CERTIFICATE OF DEATH

12232

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u> ✓			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mt. Wilson</u>		LENGTH OF STAY (in this place) <u>104 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bel Air</u> <u>12X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>State Armory</u>			
3. NAME OF DECEASED (Type or Print) <u>John Henry Campbell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11 19 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>S</u>	8. DATE OF BIRTH <u>11-25-1900</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Armory</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Henry Campbell Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Asher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u>		16. SOCIAL SECURITY NO. <u>215-18-5358</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
163X IMMEDIATE CAUSE (A) <u>Carcinoma of Lung</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-7</u> , 19 <u>59</u> , to <u>11-19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-19</u> , 19 <u>59</u> , and that death occurred at <u>9:55 P.M.</u> from the causes and on the date stated above. SIGNATURE _____ ADDRESS (Street, city, town, state) _____ DATE SIGNED _____ <u>Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11/23/59</u>		NAME OF CEMETERY OR CREMATORY <u>St Ignatius</u>		LOCATION (City, town, or county) (State) <u>Hickory, Harford Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Joseph J Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bel Air Md</u>		ADDRESS	
DATE <u>NOV 24 '59</u>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12233

CERTIFICATE OF DEATH

Reg. Dist. No.

12202

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 15 Hrs. 20 Min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 050 Veterans Administration Hospital		d. STREET ADDRESS 1716 N. Broadway Street	
3. NAME OF DECEASED (Type or print) (Served as First WILLIE Middle CARROLL Last CARROLL) WILLIAM		4. DATE OF DEATH Month November Day 9 Year 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 22, 1896
9. AGE (In years lost birthday) yrs. 63		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Fayetteville, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joe Carroll		14. MOTHER'S MAIDEN NAME Mary MN: Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 705-12-4046	
17. INFORMANT Clin. Rec., VAH, Balto. 18, Md., Ft. Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA, RIGHT LOWER LOBE 490x CONDITIONS, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) PORTAL CIRRHOSIS (c) ASCITES DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 Day Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
1. Ascites. 2. Dehydration.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 8, 1959 at 3:10 Pm toll 11/8/59 and that death occurred at 6:30 AM , from the causes and on the date stated above. alive on November 18, 1959			
ACTUAL SIGNATURE Harold R. Johnson		ADDRESS (Street, city or town, state) VAH, FT. HOWARD DIVISION BALTO. 18, MD.	
PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, M.D.		DATE SIGNED 11/9/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Lewis Mortuary		24a. REC'D BY REGISTRAR DATE NOV 10 1959	
ADDRESS Balto. Md.		24b. REGISTRAR'S SIGNATURE Arthur P. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12234

CERTIFICATE OF DEATH

Reg. Dist. No. 12203

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY 3V01-4 ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 East York Street - Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 17 East York Street	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Martha Middle Ellen Last Caviness		4. DATE OF DEATH Month Nov. Day 21 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1890
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure (grade IV) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial degeneration and Hypertrophy DUE TO (c) Arteriosclerotic cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH months years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 22 , 19 59 , to Nov. 21 , 19 59 , that I last saw the deceased alive on Nov. 20 , 19 59 , and that death occurred at 2:45 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Aristides M. Simopoulos		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 11-21-59	
PHYSICIAN'S NAME (Type) ARISTIDES M. SIMOPOULOS Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/24/59	22c. NAME OF CEMETERY OR CREMATORY HOLY CROSS	22d. LOCATION (City, town, or county) (State) BALTIMORE, MD
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, INC		ADDRESS 715 LIGHT ST BALTO. -30, MD.	
24a. REC'D BY REGISTRAR DATE NOV 24 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12204

12206

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hailthrope		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Hailthrope	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4300 Ridge Avenue		d. STREET ADDRESS 4300 Ridge Avenue	
3. NAME OF DECEASED (Type or print) First John Middle Chisley Last Chisley		4. DATE OF DEATH Month November Day 10 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1875 6/22
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 10 Days 19 Hours 59 Min.	IF UNDER 24 HRS. Hours 59 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman		10b. KIND OF BUSINESS OR INDUSTRY Pa. Railroad	
11. BIRTHPLACE (State or foreign country) Arundel County, Md.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME George Washington Chisley		14. MOTHER'S MAIDEN NAME Catherine (Maiden Name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) (Unknown)		16. SOCIAL SECURITY NO. Agnes	
17. INFORMANT Agnes		Address Agnes Chisley 4300 Ridge Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary disease & decomposition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General atherosclerosis DUE TO (c) Probable intestinal obstruction & dehydration		INTERVAL BETWEEN ONSET AND DEATH 6 or 8 months + years 46 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>		20f. (City or town) (County) (State) Baltimore Balto. Md.	
21. I certify that I attended the deceased from Nov 8 to Nov 10 , 19 59 , that I last saw the deceased alive on Nov 9 , 19 59 , and that death occurred at 9:24 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Frederic V. Beutler		ADDRESS (Street, city or town, state) 1142 Francis Ave. Balto 27 Md	
PHYSICIAN'S NAME (Type) FREDERIC V. BEUTLER		M.D. 1014	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/14/1959	
22c. NAME OF CEMETERY OR CREMATORY Arundel Memorial		22d. LOCATION (City, town, or county) (State) Arundel Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mr. Katie R. Williams		ADDRESS 322 N. Schroeder St.	
24a. REC'D BY REGISTRAR NOV 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

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THE UNIVERSITY OF CHICAGO PRESS

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
12233											
12205											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 55 Towson					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 603 Marwood Road						d. STREET ADDRESS 603 Marwood Road					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) HELEN RICHTER CLAGETT						4. DATE OF DEATH November 23 19 59					
5. SEX Female						6. COLOR OR RACE White					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH NOVEMBER 9, 1902					
9. AGE (in years last birthday) 57 yrs.						10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE						10b. KIND OF BUSINESS OR INDUSTRY OWN HOME					
11. BIRTHPLACE (State or foreign country) MARYLAND						12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME HARRY RICHTER						14. MOTHER'S MAIDEN NAME MATILDA					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NONE						16. SOCIAL SECURITY NO. NO					
17. INFORMANT MR. THOMAS J. CLAGETT III						Address 603 MARWOOD ROAD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate Intoxication.											
871.0 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Overdose of barbiturate					
20c. TIME OF INJURY Month, Day, Year 11/23 19 59						20d. INJURY OCCURRED at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home						20f. (City or town) Towson (County) Baltimore (State) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Petty						M.D. Charles S. Petty					
EXAMINER'S NAME (Type) Charles S. Petty, M.D.						DATE SIGNED 11/23/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL						22b. DATE THEREOF 11/25/59					
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY						22d. LOCATION (City, town, or country) (State) CATONSVILLE MD.					
23. FUNERAL DIRECTOR John Burns Sons						24a. REC'D BY REGISTRAR NOV 30 '59					
24b. REGISTRAR'S SIGNATURE Charles S. Petty											
VS. A15ME 5M 7/59											

12236

CERTIFICATE OF DEATH

12206

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 607 Charles St. Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jean Middle Knight Last Clarendon				4. DATE OF DEATH Month November Day 21 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1906	9. AGE (In years lost birthday) 53 yrs.	IF UNDER 1 YEAR Months 4 Days 12 Hours 30 Min.	IF UNDER 24 HRS. Hours 30 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Federal Glass Co.		11. BIRTHPLACE (State or foreign country) Bellows Falls, Vt.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Weylan C. Clarendon				14. MOTHER'S MAIDEN NAME Martha Knight			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 089-03-5842		INFORMANT Kathrine M. Clarendon		Address 607 Charles St. Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction DUE TO (c) Myocardial infarction							INTERVAL BETWEEN ONSET AND DEATH 4 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Nov Day 19 Year 1959 Hour 11 o. m. 00 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County)	(State)		
21. I certify that I attended the deceased from July 21, 1955 , to Nov 21, 1959 , that I last saw the deceased alive on Nov 19, 1959 , and that death occurred at 11:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Frederick J. Vollmer		M.D. 4100 York Rd.		ADDRESS (Street, city or town, state) Baltimore - 12, Md.		DATE SIGNED Nov 22, 1959	
PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-24-59	22c. NAME OF CEMETERY OR CREMATORY St. James Episcopal		22d. LOCATION (City, town, or county) My Monkton		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service		ADDRESS 622 York Rd.		24a. REC'D BY REGISTRAR NOV 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12237

CERTIFICATE OF DEATH

Reg. Dist. No.

12207

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 105 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HANNIBAL Middle C Last CLEMONS		4. DATE OF DEATH Month November Day 6 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 2 1893
9. AGE (In years lost birthday) yrs. 66		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY CONTRACTING CO.	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS CLEMONS		14. MOTHER'S MAIDEN NAME JANE McKEEVER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 579-01-2005	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CONGESTIVE HEART FAILURE DUE TO (c) CARCINOMA OF RECTUM		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from July 24 , 19 59 , to November 6 , 19 59 , and that death occurred at 10:40 PM , from the causes and on the date stated above. and that death occurred at 10:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Baltimore Md-Ft Howard Div. DATE SIGNED 11-7-59 ACTUAL SIGNATURE Lawrence D. Marcus M.D. VAH Baltimore Md-Ft Howard Div. 11-7-59 PHYSICIAN'S NAME (Type) Lawrence D. Marcus M.D. VAH Baltimore Md-Ft Howard Division			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/10/59	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		24a. REC'D BY REGISTRAR DATE NOV 12 '59	
ADDRESS 8728 Liberty Road Baltimore 7, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

STATE OF NEW YORK

1883

IN SENATE

JANUARY 1883

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

IN RESPONSE TO A

RESOLUTION PASSED

BY THE SENATE

APRIL 1882

ALBANY:

WEDDING

AND COMPANY

PRINTERS

1883

NEW YORK

STATE OF NEW YORK

IN SENATE

JANUARY 1883

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

12238

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>174 WINTERS AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SANDY 'COE' COLE</u>				4. DATE OF DEATH Month Day Year <u>11 10 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/9/1883</u>		9. AGE (In years lost birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRANSIT CO.</u>		11. BIRTHPLACE (State or foreign country) <u>CATONSVILLE-MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD COE</u>				14. MOTHER'S MAIDEN NAME <u>CHARITY HARRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>SEANATE C. WILLIAMS</u>		INFORMANT Address <u>174 WINTERS AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Rheumatoid Arthritis severe</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 years</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>16 Sept</u> , 19 <u>59</u> , to <u>10 Nov</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10 Nov</u> , 19 <u>59</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. R. Newman</u>				ADDRESS (Street, city or town, state) <u>305A Winters Lane</u>		DATE SIGNED <u>11/11/59</u>	
PHYSICIAN'S NAME (Type) <u>Charles Robert Davidson</u>				LOCATION (City, town, or county) (State) <u>CATONSVILLE 28 MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/14/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall F. Hays</u>				ADDRESS <u>638 N. Gilemore St</u>		24a. REC'D BY REGISTRAR <u>NOV 12 1959</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12239

CERTIFICATE OF DEATH

12209

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>570 Chalcot Square</u> <u>Baltimore Co. 21, Md.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex 21, Md.</u>		c. LENGTH OF STAY IN 1b <u>54 Essex 21, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>570 Chalcot Square</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Virginia</u> Last <u>Coleman</u>		4. DATE OF DEATH Month <u>November</u> Day <u>18</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 1, 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Tyler</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Grace Morano</u>		Address <u>570 Chalcot Sq. Essex 21, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Cardiac decompensation</u> DUE TO (b) <u>Artero-sclerotic Cardiovascular</u> DUE TO (c) <u>Chaise</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> 19 <u>53</u> to <u>Nov. 18</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 10</u> 19 <u>59</u> , and that death occurred at <u>7:35 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Miceli</u> M.D.		ADDRESS (Street, city or town, state) <u>108 S. Taylor Ave</u> DATE SIGNED <u>11/18/59</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI M.D. Baltimore 21 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-21-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Christine Brzydzinski</u> ADDRESS <u>1407 Eastern Ave</u>		24a. REC'D BY REGISTRAR <u>NOV 20 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Robert L. Hines</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12210

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

12240

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 52	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1932 Old Frederick Rd.		d. STREET ADDRESS 1932 Old Frederick Rd.	
3. NAME OF DECEASED (Type or print) Joseph P. Cooke, Sr.		4. DATE OF DEATH Month Nov. Day 22 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1916
9. AGE (in years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	
11. IF UNDER 24 HRS. Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager		10b. KIND OF BUSINESS OR INDUSTRY Geo. W. Cooke & Associates	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Cooke		14. MOTHER'S MAIDEN NAME Clementine Stickmeyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216 10 3403	
17. INFORMANT Mrs. Phyllis A. Cooke		Address 1932 Old Frederick Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Geo. S. M. Kieffer</i>		DATE SIGNED Nov. 22, 1959	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 25/59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore 29, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors		24a. REC'D BY REGISTRAR DATE NOV 24 '59	
ADDRESS 4101 B. Mondson Ave.		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kieffer</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File, pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12345

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NOT STATE
HIS DEPT.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES J. JONES		45		M		W		JAN 15 1910	
RESIDENCE		CITY		COUNTY		STATE		DECEASED	
123 Main St.		Boston		Suffolk		Mass.		JAMES J. JONES	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF EXAMINATION	
Clerk		Heart Disease		Natural		Home		JAN 15 1910	
PREVIOUS ILLNESS		SYMPTOMS		TREATMENT		POST-MORTEM		SIGNATURE OF EXAMINER	
None		Chest pain		None		No		J. J. JONES	
DATE OF BIRTH		DATE OF DEATH		DATE OF EXAMINATION		DATE OF SIGNATURE		DATE OF FILING	
JAN 1 1865		JAN 15 1910		JAN 15 1910		JAN 15 1910		JAN 15 1910	



RECORDED

12241

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>		c. LENGTH OF STAY IN 1b <u>63 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Baltimore 27.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hoxleigh Nursing Home.</u>				d. STREET ADDRESS <u>12306 Smith Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Donis</u> Middle <u>M.</u> Last <u>Cooper</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 10, 1877</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drugg</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathan Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Hyke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Informant</u>		Address <u>Living Reheve - same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> to <u>11/19/59</u> , that I last saw the deceased alive on <u>11/18/59</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3408 W. Anderson Ave</u> DATE SIGNED <u>11/19/59</u>							
ACTUAL SIGNATURE <u>Robert A. Reiter</u> M.D.				DATE SIGNED <u>11/19/59</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Reiter, M.D.</u>				<u>Baltimore 16, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-20-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Young Men</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>				24a. REC'D BY REGISTRAR <u>NOV 23 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13341

13

CERTIFICATE OF DEATH

13341



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12242
CERTIFICATE OF DEATH

12212

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> c. LENGTH OF STAY IN 1b <u>?!/</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1309 Taylor Ave.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u> d. STREET ADDRESS <u>1309 Taylor Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Terence</u> First <u>Cox</u> Middle Last			4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>1959</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>July 9, 1883</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State of Md Pen.</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>			
13. FATHER'S NAME <u>John Cox</u>				14. MOTHER'S MAIDEN NAME <u>Sarah McGuire</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>John F. Cox</u> Address <u>1309 Taylor Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Intestinal obstruction</u> DUE TO (c) <u>Carcinoma within abdomen - original site unknown?</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 weeks</u> <u>?</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			(County)		(State)		
21. I certify that I attended the deceased from <u>11/4</u> , 19 <u>54</u> , to <u>11/5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/4</u> , 19 <u>59</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George H. Beck</u> M.D.				ADDRESS (Street, city or town, state) <u>6012 Harford Road Baltimore, Md</u>			
DATE SIGNED <u>11/6/59</u>				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 9, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Baltimore</u>		(State) <u>Maryland</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u>			ADDRESS <u>3000 E. Baltimore St.</u>				
24a. REC'D BY REGISTRAR DATE <u>NOV 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12243

CERTIFICATE OF DEATH

12213

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Middle River		c. LENGTH OF STAY IN 1b 22 6 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hall Convelescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George J. Cumberland		4. DATE OF DEATH Month 11 Day 29 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1891
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pattern Maker		10b. KIND OF BUSINESS OR INDUSTRY Martins Aircraft	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Cumberland		14. MOTHER'S MAIDEN NAME Margaret Kellner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-16-9133	
17. INFORMANT Elizabeth Stoecker - 8053 Philadelphia Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 422.1 DUE TO Arteriosclerotic Cardio Vascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO disease 5 yrs (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 19 59 , to 11-29 , 19 59 , that I last saw the deceased alive on 11-29 , 19 59 , and that death occurred at 11 P. M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE JMBarmgardner M.D. Balto 6 Md.		DATE SIGNED	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-2-59	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thelma E. Swach		24a. REC'D BY REGISTRAR ADDRESS 1211 Chesaco Ave.	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE DEC 2 '59	

12243

12243

Baltimore

Baltimore

Hotel - Middle River

XX 6 mo.

Baltimore

Ivy Hall Conventual Home

1032 Baltimore Ave.

George J. Cunningham

11

22

33

Male White

X

Jan. 1, 1891

68

Patricia Baker

Martina Adams

Baltimore, Md.

U.S.A.

Henry Cunningham

Margaret Haller

10-10-9113 Kilmartin Street - 1003 Philadelphia St.

Baltimore, Md.

Secretariat General

10-1-59

1221 Centre Ave.

1

12244

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12214

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. Howard				c. LENGTH OF STAY IN 1b 64 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FREDERICK Middle J. Last DADD				4. DATE OF DEATH Month November Day 28 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 19, 1889	
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trainman				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Davenport, England	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James H. Dadd				14. MOTHER'S MAIDEN NAME Elizabeth Saunders			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 705-09-6704			
17. INFORMANT Clin. Rec., VAH Balto., Md., Ft. Howard Division				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA & EDEMA OF LUNGS DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL ARTERIOSCLEROSIS; DIABETES MELLITUS, MILD							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that VA attended the deceased from September 25, 1959 to November 28, 1959 , and that death occurred at 4:55 A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) VAH Balto., Md., Ft. Howard Div. DATE SIGNED 11/28/59							
ACTUAL SIGNATURE Harold R. Johnson M.D. VAH Balto., Md., Ft. Howard Div. 11/28/59							
PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, M.D. VAH Balto., Md., Ft. Howard Div. 11/28/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/1/59			
22c. NAME OF CEMETERY OR CREMATORY Louder Park Cemetery				22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Ambrose Inc. 1328 Sulphur Spring Rd				24a. REC'D BY REGISTRAR DATE DEC 1 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. Frank							

AMBROSE FUNERAL HOME, 1328 SULPHUR SPRING RD., BALTO. 27, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

may be retained in hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12245

CERTIFICATE OF DEATH

12215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Forest Haven Home</u>				d. STREET ADDRESS <u>R.F.D.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William E. Dailey</u> First Middle Last				4. DATE OF DEATH <u>Nov. 16</u> Month Day Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/12/72</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dailey</u>				14. MOTHER'S MAIDEN NAME <u>Riley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u> </u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>ARTERIO SCLEROSIS CARDI VASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY THROMBOSIS</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/1</u> , 19 <u>58</u> to <u>11/16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/16</u> , 19 <u>59</u> , and that death occurred at <u>10:20</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Shaw</u>				ADDRESS (Street, city or town, state) <u>5800 EDWARDS AVE BALTIMORE</u>			
PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D.</u>				DATE SIGNED <u>11/17/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-19-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McShabb & Son</u> ADDRESS <u>28</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

CERTIFICATE OF DEATH

1924

1924

1924

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]



12246

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks, Md.</u>		c. LENGTH OF STAY IN 1b <u>45 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>York Road</u>				d. STREET ADDRESS <u>York Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank Edward Daughton</u>				4. DATE OF DEATH Month Day Year <u>November 1 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 27, 1902</u>	9. AGE (In years last birthday) yrs. <u>57</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Cockeysville, Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathan Daughton</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie M. Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-16-6908</u>		INFORMANT <u>Elizabeth McCall Daughton, Sparks, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arterio-sclerotic cardio vascular disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug.</u> , 19 <u>46</u> , to <u>Nov.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>31 October</u> , 19 <u>59</u> , and that death occurred at <u>11:05 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Walter T. Kees</u> M.D. <u>Cockeysville, Md.</u> <u>November 1, 1959</u>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>Walter T. Kees</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stevenson Church Cemetery Sparks, Maryland</u>		22d. LOCATION (City, town, or county) (State) <u>(State)</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William A. Jackson</u>				ADDRESS <u>916 Pennsylvania Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 5 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kress</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

EP

12247

12217

Reg. Dist. No.

12247

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1 mth 4dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 1215 N. Augusta Avenue	
3. NAME OF DECEASED (Type or print) First Helen Middle D. Last Dauids		4. DATE OF DEATH Month November Day 17 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1897 April 22, 1897
9. AGE (In years (say birthday) yrs. 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) telephone operator	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Dailey		14. MOTHER'S MAIDEN NAME Mary Shorten	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized peritonitis 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Perforated gastric ulcer DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 16, 1959 , to Nov. 17, 1959 , that I last saw the deceased alive on Nov. 17, 1959 , and that death occurred at 11:55pM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		DATE SIGNED 11-18-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11'21'59	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		24a. REC'D BY REGISTRAR DATE NOV 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Howard			

13917

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1. PLACE OF DEATH City or town of residence of decedent		2. PLACE OF DEATH City or town of residence of decedent	
3. NAME OF DECEASED Full name of decedent		4. NAME OF DECEASED Full name of decedent	
5. SEX Male Female		6. SEX Male Female	
7. AGE At date of death		8. AGE At date of death	
9. OCCUPATION At date of death		10. OCCUPATION At date of death	
11. MARITAL STATUS Single Married Widowed Divorced		12. MARITAL STATUS Single Married Widowed Divorced	
13. DATE OF BIRTH		14. DATE OF BIRTH	
15. DATE OF DEATH		16. DATE OF DEATH	
17. TIME OF DEATH		18. TIME OF DEATH	
19. CAUSE OF DEATH Immediate cause of death		20. CAUSE OF DEATH Immediate cause of death	
21. CAUSE OF DEATH Underlying cause of death		22. CAUSE OF DEATH Underlying cause of death	
23. CAUSE OF DEATH Contributing cause of death		24. CAUSE OF DEATH Contributing cause of death	
25. CAUSE OF DEATH Manner of death		26. CAUSE OF DEATH Manner of death	
27. CAUSE OF DEATH Manner of death		28. CAUSE OF DEATH Manner of death	
29. CAUSE OF DEATH Manner of death		30. CAUSE OF DEATH Manner of death	
31. CAUSE OF DEATH Manner of death		32. CAUSE OF DEATH Manner of death	
33. CAUSE OF DEATH Manner of death		34. CAUSE OF DEATH Manner of death	
35. CAUSE OF DEATH Manner of death		36. CAUSE OF DEATH Manner of death	
37. CAUSE OF DEATH Manner of death		38. CAUSE OF DEATH Manner of death	
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43. CAUSE OF DEATH Manner of death		44. CAUSE OF DEATH Manner of death	
45. CAUSE OF DEATH Manner of death		46. CAUSE OF DEATH Manner of death	
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49. CAUSE OF DEATH Manner of death		50. CAUSE OF DEATH Manner of death	
51. CAUSE OF DEATH Manner of death		52. CAUSE OF DEATH Manner of death	
53. CAUSE OF DEATH Manner of death		54. CAUSE OF DEATH Manner of death	
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69. CAUSE OF DEATH Manner of death		70. CAUSE OF DEATH Manner of death	
71. CAUSE OF DEATH Manner of death		72. CAUSE OF DEATH Manner of death	
73. CAUSE OF DEATH Manner of death		74. CAUSE OF DEATH Manner of death	
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79. CAUSE OF DEATH Manner of death		80. CAUSE OF DEATH Manner of death	
81. CAUSE OF DEATH Manner of death		82. CAUSE OF DEATH Manner of death	
83. CAUSE OF DEATH Manner of death		84. CAUSE OF DEATH Manner of death	
85. CAUSE OF DEATH Manner of death		86. CAUSE OF DEATH Manner of death	
87. CAUSE OF DEATH Manner of death		88. CAUSE OF DEATH Manner of death	
89. CAUSE OF DEATH Manner of death		90. CAUSE OF DEATH Manner of death	
91. CAUSE OF DEATH Manner of death		92. CAUSE OF DEATH Manner of death	
93. CAUSE OF DEATH Manner of death		94. CAUSE OF DEATH Manner of death	
95. CAUSE OF DEATH Manner of death		96. CAUSE OF DEATH Manner of death	
97. CAUSE OF DEATH Manner of death		98. CAUSE OF DEATH Manner of death	
99. CAUSE OF DEATH Manner of death		100. CAUSE OF DEATH Manner of death	

Burial 11/21/59 New Cathedral Cemetery, Baltimore, Maryland
 Howard H. Hubbard XX #107 Wilkens Ave.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12218

Reg. Dist. No.

12196

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	c. LENGTH OF STAY IN 1b ?	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Res., 2076 Larkhall Road		e. IS RESIDENCE ON XXXX YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Franklin Last Davis		4. DATE OF DEATH Month Nov. Day 6, Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1923 35 yrs.
9. AGE (In years last birthday) 35		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery Clerk	11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Mims Davis		14. MOTHER'S MAIDEN NAME Lexie Rivers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) Yes Navy, WWII		16. SOCIAL SECURITY NO. 251-26-2994	
17. INFORMANT Mrs. Azilee Davis		Address 2076 Larkhall Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STRANGULATION = (HANGING) 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH _____
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hung Self from Stranway RAILING	
20c. TIME OF INJURY Month, Day, Year 8:30 a.m. 11-6-59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. CITY or town (County) (State) Dundalk - Baltimore
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. DAVIS M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 10-59	22c. NAME OF CEMETERY OR CREMATORY Chesterfield, South Carolina
22d. LOCATION (City, town, or county) (State) Chesterfield, South Carolina			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda 7922 Wise Ave. 22, Maryland		24a. REC'D BY REGISTRAR DATE NOV 9 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12136

12136

NEW YORK STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

12248

CERTIFICATE OF DEATH

Reg. Dist. No. 12219

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore County</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maryland Masonic Homes</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Anna</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>November</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 11, 1870</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME (unknown) Weiss				14. MOTHER'S MAIDEN NAME Emma Wimmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>G M Bosley - Masonic Home - Cockeysville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-Sclerotic Cardio Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 25, 1956</u> , to <u>Nov. 18, 1959</u> , that I last saw the deceased alive on <u>Nov. 18, 1959</u> , and that death occurred at <u>4:40 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter T. Keas</u>				ADDRESS (Street, city or town, state) <u>Cockeysville, Maryland</u>		DATE SIGNED <u>Nov. 18, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Walter T. Keas</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-21-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc. 1217 St. Paul Street</u>				24. REC'D BY REGISTRAR DATE <u>NOV 20 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2248

15519

1. NAME OF DECEASED JOHN J. JONES		2. SEX Male		3. AGE 45		4. DATE OF BIRTH Jan 15, 1873		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Carpenter		7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF DEATH Home		10. DATE OF DEATH Jan 20, 1918	
11. SIGNATURE OF PHYSICIAN J. H. Smith		12. SIGNATURE OF CLERK A. B. Jones		13. SIGNATURE OF WITNESS C. D. Brown		14. SIGNATURE OF DECEASED John J. Jones		15. SIGNATURE OF NEAREST RELATIVE Mary J. Jones	
16. NAME OF CLERK A. B. Jones		17. NAME OF PHYSICIAN J. H. Smith		18. NAME OF WITNESS C. D. Brown		19. NAME OF DECEASED John J. Jones		20. NAME OF NEAREST RELATIVE Mary J. Jones	
21. NAME OF CLERK A. B. Jones		22. NAME OF PHYSICIAN J. H. Smith		23. NAME OF WITNESS C. D. Brown		24. NAME OF DECEASED John J. Jones		25. NAME OF NEAREST RELATIVE Mary J. Jones	
26. NAME OF CLERK A. B. Jones		27. NAME OF PHYSICIAN J. H. Smith		28. NAME OF WITNESS C. D. Brown		29. NAME OF DECEASED John J. Jones		30. NAME OF NEAREST RELATIVE Mary J. Jones	
31. NAME OF CLERK A. B. Jones		32. NAME OF PHYSICIAN J. H. Smith		33. NAME OF WITNESS C. D. Brown		34. NAME OF DECEASED John J. Jones		35. NAME OF NEAREST RELATIVE Mary J. Jones	
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41. NAME OF CLERK A. B. Jones		42. NAME OF PHYSICIAN J. H. Smith		43. NAME OF WITNESS C. D. Brown		44. NAME OF DECEASED John J. Jones		45. NAME OF NEAREST RELATIVE Mary J. Jones	
46. NAME OF CLERK A. B. Jones		47. NAME OF PHYSICIAN J. H. Smith		48. NAME OF WITNESS C. D. Brown		49. NAME OF DECEASED John J. Jones		50. NAME OF NEAREST RELATIVE Mary J. Jones	
51. NAME OF CLERK A. B. Jones		52. NAME OF PHYSICIAN J. H. Smith		53. NAME OF WITNESS C. D. Brown		54. NAME OF DECEASED John J. Jones		55. NAME OF NEAREST RELATIVE Mary J. Jones	
56. NAME OF CLERK A. B. Jones		57. NAME OF PHYSICIAN J. H. Smith		58. NAME OF WITNESS C. D. Brown		59. NAME OF DECEASED John J. Jones		60. NAME OF NEAREST RELATIVE Mary J. Jones	
61. NAME OF CLERK A. B. Jones		62. NAME OF PHYSICIAN J. H. Smith		63. NAME OF WITNESS C. D. Brown		64. NAME OF DECEASED John J. Jones		65. NAME OF NEAREST RELATIVE Mary J. Jones	
66. NAME OF CLERK A. B. Jones		67. NAME OF PHYSICIAN J. H. Smith		68. NAME OF WITNESS C. D. Brown		69. NAME OF DECEASED John J. Jones		70. NAME OF NEAREST RELATIVE Mary J. Jones	
71. NAME OF CLERK A. B. Jones		72. NAME OF PHYSICIAN J. H. Smith		73. NAME OF WITNESS C. D. Brown		74. NAME OF DECEASED John J. Jones		75. NAME OF NEAREST RELATIVE Mary J. Jones	
76. NAME OF CLERK A. B. Jones		77. NAME OF PHYSICIAN J. H. Smith		78. NAME OF WITNESS C. D. Brown		79. NAME OF DECEASED John J. Jones		80. NAME OF NEAREST RELATIVE Mary J. Jones	
81. NAME OF CLERK A. B. Jones		82. NAME OF PHYSICIAN J. H. Smith		83. NAME OF WITNESS C. D. Brown		84. NAME OF DECEASED John J. Jones		85. NAME OF NEAREST RELATIVE Mary J. Jones	
86. NAME OF CLERK A. B. Jones		87. NAME OF PHYSICIAN J. H. Smith		88. NAME OF WITNESS C. D. Brown		89. NAME OF DECEASED John J. Jones		90. NAME OF NEAREST RELATIVE Mary J. Jones	
91. NAME OF CLERK A. B. Jones		92. NAME OF PHYSICIAN J. H. Smith		93. NAME OF WITNESS C. D. Brown		94. NAME OF DECEASED John J. Jones		95. NAME OF NEAREST RELATIVE Mary J. Jones	
96. NAME OF CLERK A. B. Jones		97. NAME OF PHYSICIAN J. H. Smith		98. NAME OF WITNESS C. D. Brown		99. NAME OF DECEASED John J. Jones		100. NAME OF NEAREST RELATIVE Mary J. Jones	

RECEIVED
JAN 22 1918
BALTIMORE, MD.

12207

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Halethorpe</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5654 Carville Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillian M. Dawson</u>		4. DATE OF DEATH Month Day Year <u>November 24 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1898</u> 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Dawson</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Biggs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Florence E. Dawson 5654 Carville Ave</u>	
17. INFORMANT Address <u>Florence E. Dawson 5654 Carville Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Rheumatic Valvular Heart Disease Undet</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, Secondary.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 10</u> , 19 <u>57</u> , to <u>Nov 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 20</u> , 19 <u>59</u> , and that death occurred at <u>11:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bradley Daugherty</u> M.D.		ADDRESS (Street, city or town, state) <u>1264 Francis Ave. Balto 27 Md</u> DATE SIGNED <u>11-25-59</u>	
PHYSICIAN'S NAME (Type) <u>Bradley A. Daugherty</u>		<u>1264 Francis Ave (27)</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ambrose, Inc. 1328 Sulphur Spring Rd</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 27 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hunter</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12221

12249

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenarm Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sister Mary Fidelia De Katow</u> Middle <u>De Katow</u> Last <u>De Katow</u>		4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 3, 1867</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS.</u>	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alphonse De Katow</u>		14. MOTHER'S MAIDEN NAME <u>Noemie ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Sister M. Peter Fourier</u>		Address <u>Notch Cliff, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of bowels</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug.</u> , 19 <u>54</u> , to <u>November</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>November 24</u> , 19 <u>59</u> , and that death occurred at <u>7:10 A.M.</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D. <u>7501 York Road Towson, 4, Md.</u>		<u>11/25/59</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-27-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>NOTCH CLIFF NR TOWSON, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Zeller</u> ADDRESS <u>901 S. CONKLING ST. BALTO, 24, MD</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 27 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12250

CERTIFICATE OF DEATH

12222

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN 1b 2 1/2 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				d. STREET ADDRESS 1322 MORLING AVE			
3. NAME OF DECEASED (Type or print) First Middle Last BERTHA HELEN DIVEN				4. DATE OF DEATH Month Day Year NOV 12 1957			
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-13-1883	9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S.				13. FATHER'S NAME GILBERT J. BUNN			
14. MOTHER'S MAIDEN NAME KATHERINE LUTZ				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT Address Frank L. Smith Jr. - Cockeysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Vascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cockeysville, Md.				20g. (County) Cockeysville, Md.		20h. (State) Md.	
21. I certify that I attended the deceased from 5/15 , 19 57 , to 11/11 , 19 57 , that I last saw the deceased alive on 11/11 , 19 57 , and that death occurred at 4:10 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cockeysville, Md. DATE SIGNED 11/12/59 ACTUAL SIGNATURE Robert J. Kues M.D. PHYSICIAN'S NAME (Type) Robert J. Kues							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-14-59		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE NOV 13 '59		24b. REGISTRAR'S SIGNATURE Conrad & Kues	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 1893 CERTIFICATE OF DEATH	
1. NAME OF DECEASED JAMES M. HARRIS	
2. SEX Male	
3. AGE 35 years	
4. DATE OF DEATH April 10, 1893	
5. PLACE OF DEATH Baltimore, Md.	
6. CAUSE OF DEATH Typhoid fever	
7. DISEASE OR INJURY Typhoid fever	
8. OCCASION OF DEATH At home	
9. SIGNATURE OF PHYSICIAN J. M. Harris	
10. SIGNATURE OF WITNESSES J. M. Harris	
11. SIGNATURE OF DECEASED J. M. Harris	
12. SIGNATURE OF REGISTRAR J. M. Harris	
13. SIGNATURE OF CLERK J. M. Harris	
14. SIGNATURE OF DECEASED J. M. Harris	
15. SIGNATURE OF WITNESSES J. M. Harris	
16. SIGNATURE OF DECEASED J. M. Harris	
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98. SIGNATURE OF DECEASED J. M. Harris	
99. SIGNATURE OF WITNESSES J. M. Harris	
100. SIGNATURE OF DECEASED J. M. Harris	

This certificate is to be filled out by the physician or other person who has attended the deceased, and is to be filed in the office of the Registrar of Deaths, Baltimore, Maryland, within ten days of the date of death. It is to be filled out in duplicate, one copy to be filed in the office of the Registrar, and the other to be retained by the physician or other person who has attended the deceased.

12251

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 147 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 44 "B" Street			
3. NAME OF DECEASED (Type or print) First CARROLL Middle S. Last DIVEN				4. DATE OF DEATH Month November Day 6 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 11, 1925	
9. AGE (In years lost birthday) yrs. 33		10. IF UNDER 1 YEAR Months 33 Days 16 Hours 41 Min. 2		11. IF UNDER 24 HRS. Hours 16 Min. 41		12. IF UNDER 24 HRS. Hours 16 Min. 41	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Driver				10b. KIND OF BUSINESS OR INDUSTRY Taxicab Co.		11. BIRTHPLACE (State or foreign country) Laurel, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George E. Diven				14. MOTHER'S MAIDEN NAME Mary Geis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW 11 218-12-7769			
17. INFORMANT Clin. Records, VAH, Balto 18, Md. Ft. Howard Div				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HODGKINS DISEASE WITH INVOLVEMENT OF LYMPH NODES 201X INDEX SPLEEN, LIVER AND LUNGS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) JAUNDICE DUE TO COMPRESSION OF COMMON BILE DUCT INDEX (c) CACHEXIA MODERATE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CACHEXIA MODERATE							
INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that VA attended the deceased from June 12, 1959 to November 6, 1959 , and that death occurred at 2:25 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Caridad E. Gonzalez M.D. VAH BALTO MD. FT HOWARD DIVISION 11/6/59							
PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M. D. VAH BALTO MD. FT HOWARD DIVISION 11/6/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal							
22b. DATE THEREOF 11-6-59							
22c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery							
22d. LOCATION (City, town, or county) (State) Laurel, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm Cook Blight Funeral Home 6009 Harford Rd. Balto. Md.							
24a. REC'D BY REGISTRAR NOV 10 '59							
24b. REGISTRAR'S SIGNATURE Arthur S. Kinn							

1

050

1

2

1

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Delivered by Hearse to: DEWITT DONALDSON FUNERAL HOME, LAUREL, MD.

12553

CERTIFICATE OF DEATH

12551

1. Name of deceased: James H. Brown

2. Sex: Male

3. Age: 45

4. Date of death: December 11, 1955

5. Place of death: Home

6. Cause of death: Heart disease

7. Signature of physician: [Signature]

8. Signature of registrar: [Signature]

9. Date of registration: December 12, 1955

10. Place of registration: City of New York

12252

CERTIFICATE OF DEATH

12224

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 11mth29dys			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville, Md. 18x-2				d. STREET ADDRESS -			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bessie Middle Mary Last Dolby				4. DATE OF DEATH Month November Day 23 Year 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 9, 1886	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Whittington				14. MOTHER'S MAIDEN NAME Sara Chaney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 794x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERAL DEBILITY DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 8, 1959 , to NOV. 23, 1959 , that I last saw the deceased alive on NOV. 23, 1959 , and that death occurred at 10:19 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE P. K. Yip				ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) P. K. Yip				Catonsville 28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 25-59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Sentland Md	
23. FUNERAL DIRECTOR'S SIGNATURE SIMMONS				ADDRESS Bros. 1661-400d Hope Rd S.E.		24a. RECEIVED BY REGISTRAR DATE NOV 25 59	
				24b. REGISTRAR'S SIGNATURE Edward S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12225

Reg. Dist. No.

12253

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown			c. LENGTH OF STAY IN 1b 47 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3414 Chapman Road				d. STREET ADDRESS 3414 Chapman Road		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First Frank Middle W. Last Doran				4. DATE OF DEATH Month Nov. Day 7, Year 1959			
5. SEX M.		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> WIDOWED		8. DATE OF BIRTH March 8, 1885	
				9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Shane Balto. Co; Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Columbus Doran				14. MOTHER'S MAIDEN NAME Huldah Mc Collough			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. *****		17. INFORMANT Address Randallstown, Md Mrs. Daisie V. Doran 3414 Chapman Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 416X DUE TO Conditions, if any, which gave rise to immediate cause (b) Rheumatic Heart Disease (c) 5 yr. est. DUE TO cause last.							INTERVAL BETWEEN ONSET AND DEATH 1 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) none							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) D. D. Caples M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		11-9-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/10/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		22d. LOCATION (City, town, or county) (State) Randallstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers				ADDRESS 8728 Liberty Road		24a. REC'D BY REGISTRAR DATE NOV 12 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Hume	
Randallstown, Md.							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1888

Name of Deceased		Date of Death	
John Doe		Jan 1, 1900	
Age		Sex	
35		Male	
Place of Birth		Cause of Death	
Baltimore, Md.		Heart Disease	
Occupation		Signature of Medical Examiner	
Teacher		J. A. Smith	
Residence		Date of Examination	
123 Main St.		Jan 1, 1900	
City		County	
Baltimore		Baltimore	
State		Signature of Registrar	
Maryland		J. B. Jones	
Date of Registration		Signature of Physician	
Jan 1, 1900		D. C. Green	
Signature of Medical Examiner		Signature of Registrar	
J. A. Smith		J. B. Jones	
Signature of Physician		Signature of Medical Examiner	
D. C. Green		J. A. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove capbox papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

SALARY STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22b, Film G252 11/18/59 iwk

12254

CERTIFICATE OF DEATH

Reg. Dist. No.

12226

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge d. STREET ADDRESS Route 4, Box 229 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEROY Middle F. Last DORSEY		4. DATE OF DEATH Month November Day 8 Year 1959			
5. SEX White Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 30, 1924	9. AGE (In years lost birthday) 35 yrs.	10. IF UNDER 1 YEAR Months 13 Days x Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Elkridge, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel F. Dorsey		14. MOTHER'S MAIDEN NAME Olie Dunkerley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW II 219-18-6371		INFORMANT Address Clin. Rec. VAH, Balto. 18, Md. Fort Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LAENNEC'S CIRRHOSIS 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH, BALTO. 18, MD. FT. HOWARD DIVISION	
20f. (City or town) Elkridge, Maryland		(County) Howard		(State) Maryland	
21. I certify that I attended the deceased from Nov. 6, 1959 to Nov. 8, 1959 , and that death occurred at 8:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO. 18, MD. FT. HOWARD DIVISION DATE SIGNED 11/9/59					
ACTUAL SIGNATURE Lawrence J. Mazzei, M.D.					
PHYSICIAN'S NAME (Type) LAWRENCE J. MAZZEI, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 12, 1959		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	
22d. LOCATION (City, town, or county) Elkridge, Maryland		(State) Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Higinbotham Funeral Home	
24a. REC'D BY REGISTRAR DATE NOV 13 '59		24b. REGISTRAR'S SIGNATURE Arthur J. K...			

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

[Illegible text]

1990

Adm. Comm.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12255

CERTIFICATE OF DEATH

Reg. Dist. No.

12227

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITE MARSH		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X WHITE MARSH	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 812 ALLANDER ROAD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GRAFTON Middle Last DULANEY		4. DATE OF DEATH Month NOV Day 28 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 21, 1886
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
11. BIRTHPLACE (State or foreign country) VIRGINIA GREEN Co		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME GEORGE WASHINGTON DULANEY		14. MOTHER'S MAIDEN NAME ALAMETA UNKNOWN.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-30-304	
17. INFORMANT JOHN SMITH		Address 812 ALLANDER ROAD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis & Chronic Bronchitis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 27, 1958 , to Nov. 28, 1959 that I last saw the deceased alive on Nov. 27, 1959 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kingsville, Md. DATE SIGNED 11-28-59			
ACTUAL SIGNATURE William G. Tyson M.D.		PHYSICIAN'S NAME (Type) Clifford F. Hudson Fork. Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC 2, 1959	
22c. NAME OF CEMETERY OR CREMATORY PIUE GROVE.		22d. LOCATION (City, town, or county) (State) PARKTON. MARYLAND.	
23. FUNERAL DIRECTOR'S SIGNATURE Sassahn Funeral Home		24a. REC'D BY REGISTRAR DATE DEC 2 '59	
ADDRESS 7401 Belair Road #6		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

13332

CERIFICATE OF DEATH

13332

DEATH

WILLIAM

DEATH

WHITE

WHITE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12256

CERTIFICATE OF DEATH

12228

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 25 Days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JAMES Middle --- Last DUMPSON			4. DATE OF DEATH Month November Day 17 Year 19 59		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 28, 1902		9. AGE (In years last birthday) yrs. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME James Dumpson			14. MOTHER'S MAIDEN NAME Louisa Stevenson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-05-4461	INFORMANT Address Clin. Rec., VAH, Baltimore 18, Md., Ft. Howard Div.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA 590X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) UREMIA DUE TO (c) ACUTE AND CHRONIC RENAL DISEASE					INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES UNKNOWN UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
1. Pulmonary emphysema. 2. Obesity.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from October 23, 1959 to November 17, 1959 and that death occurred at 4:34 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTIMORE 18, MD., FT. HOWARD DIV. 11/17/59					
ACTUAL SIGNATURE John W. Crawford		M.D. VAH, BALTIMORE 18, MD., FT. HOWARD DIV. 11/17/59			
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH, BALTIMORE 18, MD., FT. HOWARD DIV. 11/17/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-20-59	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE George Kelson		ADDRESS 1348 N. Calhoun St. Balto. Md.	24a. REC'D BY REGISTRAR NOV 18 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained in hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12328

CERTIFICATE OF DEATH

12328

Deceased

Male (55)

111 North Street, New York

October 27, 1955

October 28, 1955

Deceased

Deceased

Deceased, New York, N.Y., 10001

10001

10001

10001

10001

Deceased, New York, N.Y., 10001

Deceased, New York, N.Y., 10001

Deceased, New York, N.Y., 10001

Deceased, New York, N.Y., 10001

Deceased, New York, N.Y., 10001

Deceased, New York, N.Y., 10001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G252 11-16-59 et

12257

CERTIFICATE OF DEATH

12229

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 29 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Augsburg Home		d. STREET ADDRESS 414 Kensington Road Campfield Road	
3. NAME OF DECEASED (Type or print) First Middle Last Lulie Mary Eckhardt		4. DATE OF DEATH Month Day Year Nov. 4, 1959 19	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/12/1882
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Schmelz		14. MOTHER'S MAIDEN NAME Fredericka Schmelz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Mr. Arthur E. Rudolphi		Address 414 Kensington Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Atherosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fracture of left Hip Aug. - 1959		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell in Room - Getting out of Bed -	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 10 8 / 29 1959		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Augsburg Home		20f. (City or town) (County) (State) Balto - Ind. - Ind.	
21. I certify that I attended the deceased from Nov. 4, 1959 to Nov. 4, 1959 , that I last saw the deceased alive on Nov. 3, 1959 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl L. Chambers		M.D. 4108 Liberty Hts. Balto Ind. 11-6-59	
PHYSICIAN'S NAME (Type) Earl L. Chambers		4108 Liberty Hts. Balto - Ind. 11-6-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 7, 1959	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JT Stansbury		ADDRESS 6411 Windsor Mill Rd.	
24a. REC'D BY REGISTRAR DATE NOV 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

12258

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 44 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GRENVILLE Middle L Last FOWLER				4. DATE OF DEATH Month November Day 26 Year 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 31, 1907	
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Washington DISTRICT OF COLUMBIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY				10b. KIND OF BUSINESS OR INDUSTRY LAW			
13. FATHER'S NAME OWEN H. FOWLER				14. MOTHER'S MAIDEN NAME ELIZA LEWIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. WW-11			
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BLEEDING ESOPHAGEAL VARICES 462.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PORTAL CIRRHOSIS OF LIVER (c) EDEMA OF LUNGS							INTERVAL BETWEEN ONSET AND DEATH FEW HOURS UNKNOWN FEW HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
1. Acute Pancreatitis - 2 to 3 Days. 2. Acute Pyelonephritis - 1 Week							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from October 13, 1959 , to November 26, 1959 , and that death occurred 11:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Armen Bogosian</i>				DATE SIGNED 11/27/59			
PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN, M.D.				M.D. VAH, BALTO. 18, MD. FT. HOWARD DIV.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-1-59		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WM. COOK-BLIGHT INC				ADDRESS 6009 Harford Road Baltimore 14 Maryland		24a. REC'D BY REGISTRAR DEC 2 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1938

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH
 OCCUPATION
 CAUSE OF DEATH
 PLACE OF DEATH
 TIME OF DEATH
 SIGNATURE OF REGISTRAR
 SIGNATURE OF MEDICAL OFFICER
 SIGNATURE OF WITNESSES

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH
 OCCUPATION
 CAUSE OF DEATH
 PLACE OF DEATH
 TIME OF DEATH
 SIGNATURE OF REGISTRAR
 SIGNATURE OF MEDICAL OFFICER
 SIGNATURE OF WITNESSES

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH
 OCCUPATION
 CAUSE OF DEATH
 PLACE OF DEATH
 TIME OF DEATH
 SIGNATURE OF REGISTRAR
 SIGNATURE OF MEDICAL OFFICER
 SIGNATURE OF WITNESSES

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH
 OCCUPATION
 CAUSE OF DEATH
 PLACE OF DEATH
 TIME OF DEATH
 SIGNATURE OF REGISTRAR
 SIGNATURE OF MEDICAL OFFICER
 SIGNATURE OF WITNESSES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12259

12231

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 176 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 6400 Old Harford Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH AUSTIN RACHA Middle FRIDINGER Last FRIDINGER				4. DATE OF DEATH Month November Day 22 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1879	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 80 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) York County, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
3. FATHER'S NAME Joseph Fridinger				14. MOTHER'S MAIDEN NAME Mary Stonecifer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. SPANISH AMERICAN None		INFORMANT Clin. Records, Vet. Adm. Hosp. Balto. Md. Ft. Howard Div		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 493X IMMEDIATE CAUSE (a) PULMONARY EMBOLISM DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PNEUMONIA DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 to 2 DAYS 1 WEEK	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 30 , 19 59 , to November 22 , 19 59 , and that death occurred at 2:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTIMORE, MD. FT HOWARD DIV DATE SIGNED 11/22/59 ACTUAL SIGNATURE George C. McElpatrick MD M.D. VAH, BALTIMORE, MD. FT HOWARD DIV 11/22/59 PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK M.D. VAH, BALTIMORE, MD. FT HOWARD DIV 11/22/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Brial		22b. DATE THEREOF 11-25-59		22c. NAME OF CEMETERY OR CREMATORY MONKTON M.E. CHURCH CEMETERY		22d. LOCATION (City, town, or county) (State) MONKTON MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WM. COOK-BLIGHT, INC., BALTIMORE, MARYLAND				24a. REC'D BY REGISTRAR NOV 27 59		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

CERTIFICATE OF DEATH

12323



ATTEST

TESTAMENTS

NOTARY

DECEASED

DATE

TIME

PLACE

CAUSE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

CERTIFICATE OF DEATH

12232

Reg. Dist. No.

12250

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1407 Shefford Road				d. STREET ADDRESS 1407 Shefford Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last GENEVIEVE GARDINA				4. DATE OF DEATH Month Day Year Nov. 12 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/27/1913	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY R.H. Donnelly Co		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Hill				14. MOTHER'S MAIDEN NAME Elizabeth Hayes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Frank R. Gardina, husband, above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 449X DUE TO Hypertensive Cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1948 , to Nov 12, 1959 , that I last saw the deceased alive on Nov 11, 1959 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Albert Scagnetti				ADDRESS (Street, city or town, state) 1744 Lombard St Baltimore Md		DATE SIGNED 11-13-59	
PHYSICIAN'S NAME (Type) A. Scagnetti							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/16/59		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.				24a. REC'D BY REGISTRAR NOV 16 '59		24b. REGISTRAR'S SIGNATURE Carlton & Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22B Film 6255 12/3/59 1wk

12233

12261

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 46 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 4520 Schenley Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALCAEUS Middle R. Last GARRETT				4. DATE OF DEATH Month November Day 24 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/27/92	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 3 Days 0 Hours 1 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur				10b. KIND OF BUSINESS OR INDUSTRY Stieff Silver Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George E. Garrett				14. MOTHER'S MAIDEN NAME Nettie Kershaw			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 215-01-7100			
INFORMANT Clin. Rec. VAH, Balto., Md. Ft. Howard Division				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA MIDDLE THIRD ESOPHAGUS. PULMONARY EMPHYSEMA							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from October 9, 1959 to November 24, 1959 , and that death occurred at 1:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO. MD. FORT HOWARD DIVISION DATE SIGNED 11/24/59							
ACTUAL SIGNATURE L. Bruce Smith M.D. VAH, BALTO. MD. FORT HOWARD DIVISION							
PHYSICIAN'S NAME (Type) L. BRUCE SMITH, M.D. VAH, BALTO, MD. FORT HOWARD DIVISION							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 27, 1959		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Horace Burgee Funeral Home, Baltimore, Maryland				24a. REC'D BY REGISTRAR NOV 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-1383

REPUBLIC OF DEATH

1383

Callahan
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CERTIFICATE OF DEATH

Reg. Dist. No.

12262

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Warren Middle Gerrits Last Gerrits		4. DATE OF DEATH Month November Day 5 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1886
9. AGE (In years lost birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plant man	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plant man		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Gerrits		14. MOTHER'S MAIDEN NAME Amelia Granger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized peritonitis 570.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Volvulus of the sigmoid colon DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral vascular accident			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 27, 1959 to Nov. 5, 1959 , that I last saw the deceased alive on Nov. 5, 1959 , and that death occurred at 1:50 a.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 11-5-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 7, 1959	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Wheaton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Garcho Sons Baltimore Md		24a. REC'D BY REGISTRAR DATE NOV 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Klaus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12235

12263

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elliot City, P.O.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elliot City, P.O.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <u>Jonnycake Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>M.</u> Last <u>Gettings</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 29, 1862</u>
9. AGE (In years last birthday) <u>96</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner of farm, Jonnycake Rd, Elliot</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Gettings</u>		14. MOTHER'S MAIDEN NAME <u>Anna Vedaker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs Emma H. Gettings</u>		Address <u>Jonnycake Rd, Elliot City</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cyelonephritis</u> 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic urinary tract infection</u> DUE TO (c) <u>Benign prostatic hypertrophy</u> * 2 year PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus; Arteriosclerotic ht. dis.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 8, 1959</u> to <u>11/6, 1959</u> , that I last saw the deceased alive on <u>11/6, 1959</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Christian S. Mass</u> M.D.		ADDRESS (Street, city or town, state) <u>11 E. Chase Street, 4/3/59</u>	
PHYSICIAN'S NAME (Type) <u>Christian S. Mass</u>		BALTIMORE 2, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/9/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u> ADDRESS <u>8725 Liberty Road, Randallstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Ernest J. Knecht</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

TAMM BROWN

1933

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

FILE NO. 10

REPORT

Name of Deceased		TAMM BROWN	
Date of Birth			
Sex			
Race			
Marital Status			
Occupation			
Usual Residence			
Place of Death			
Cause of Death			
Manner of Death			
Physician's Signature			
Date of Report			
Registrar's Signature			
Date of Registration			
County			
City			
State			

12237

12264

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>108 Linden Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES MCKINSEY GILLESPIE</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 6, 1906</u>
9. AGE (In years lost birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Division of Staunton, Va.</u>	
13. FATHER'S NAME <u>Michael Gillespie</u>		14. MOTHER'S MAIDEN NAME <u>P.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-03-8298</u>	
17. INFORMANT <u>Mrs Crystal Gillespie (Sister.)</u>		18. ADDRESS <u>(Same.)</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO <u>Coronary artery occlusion</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Coronary atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>59</u> , and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above. <u>2 did not attend deceased. Case discussed with Dr. Smith at medical examiner's office.</u> ACTUAL SIGNATURE <u>Richard N. Tillman</u> M.D. <u>3035 S. Paulist Baltimore, Md</u> DATE SIGNED <u>Nov 24, 1959</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD N. TILLMAN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 27, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>North Canton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>North Canton Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henn W. Jenkins & Sons, Co.</u>		24. REC'D BY REGISTRAR DATE <u>NOV 27 '59</u>	
ADDRESS <u>4905 York Road,</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

VS TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

12291

NEW HAMPSHIRE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

12291

III

Warrant County, New Hampshire

Belmont

Town

Town

108 Union Street

108 Union Street

July 22, 1909

CHARLES M. HAYES, CLERK

Age 61

Male

Married

Single

Residence (same)

20

On July 22, 1909, at Belmont, New Hampshire, I, the undersigned, Clerk of the Town of Belmont, do hereby certify that the within and foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears from the records of the Town of Belmont, New Hampshire, for the year 1909.

Witness my hand and the seal of the Town of Belmont, New Hampshire, this 22nd day of July, 1909.

Charles M. Hayes, Clerk



Item 14 FilmG252 11-24-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12239

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 565 Brook Road				d. STREET ADDRESS 565 Brook Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last SALVATORE GIZZI				4. DATE OF DEATH Month Day Year November 14, 1959					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 1, 1877			
				9. AGE (In years last birthday) yrs. 82		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Concrete Worker		10b. KIND OF BUSINESS OR INDUSTRY Concrete Const. Co.		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Michael Gizzi				14. MOTHER'S MAIDEN NAME diPennacchia Maria Gizzi					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Donado Gizzi, 565 Brook Rd., Towson 4, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONGESTIVE HEART FAILURE DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE								INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 3-4 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURE OF HIP								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) FELL AT HOME		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. JUNE 1959 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) BALTO. CO. MD.			
21. I certify that I attended the deceased from 10/5 , 19 58 , to 11/14 , 19 59 , that I last saw the deceased alive on 11/13 , 19 59 , and that death occurred at 3:20 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 17 W. PENNA. AV. TOWSON 4 MD. DATE SIGNED 11/17/59									
ACTUAL SIGNATURE T. C. Siwinski		M.D. TOWSON 4 MD.							
PHYSICIAN'S NAME (Type) T. C. SIWINSKI									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 17, 1959		22c. NAME OF CEMETERY OR CREMATORY Mt. Maria Cemetery		22d. LOCATION (City, town, or county) (State) Towson, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland				ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			
				24a. REC'D BY REGISTRAR DATE NOV 19 1959					

12225

Barbino

Townson

565 Brook Road

BALWORTHY, GERALD

November 14,

65

January 1, 1977

x

with

Male

Concrete Worker

Concrete Const. Co. Italy

Michael Clark

Marble Clark

Home

No

Tonando Clark, 565 Brook Rd., Townson, A. P.

Townson, Maryland

Nov. 17, 1979, 14, 1979, 14, 1979, 14, 1979

John Smith, Son, Townson, Maryland

12266

CERTIFICATE OF DEATH

12240

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>17yr9mth4dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>Linthicum, Md.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>Fred</u> Last <u>Glanzer</u>				4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 6, 1880</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B & O Rail Road</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Germany U.S.A.</u>							
13. FATHER'S NAME <u>William Glanzer</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Hannibal</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure with pleural effusion</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>May 13</u> , 19 <u>59</u> , to <u>November 25</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 25</u> , 19 <u>59</u> , and that death occurred at <u>1:05p</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u>				DATE SIGNED <u>11-25-59</u>			
ACTUAL SIGNATURE <u>Aristides Simopoulos</u>				M.D. <u>SPRING GROVE STATE HOSPITAL</u>			
PHYSICIAN'S NAME (Type) <u>Aristides Simopoulos, M. D.</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 28, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cem</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Truman Schwaib</u>				ADDRESS <u>3512 Frederick Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>G. L. H. H.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12241

12267

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. STREET ADDRESS 6510 Brighton Avenue			
3. NAME OF DECEASED (Type or print) First Frank W. Middle Golebieski (or Goblieski) Last 				4. DATE OF DEATH Month November Day 9 Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Unknown 10/3/1910	9. AGE (In years last birthday) 49?	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Balto. Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown Joseph Golebieski				14. MOTHER'S MAIDEN NAME Viola Miros			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown NO		16. SOCIAL SECURITY NO. 215-09-9431		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver with hemorrhage 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Sept. 17 , 19 59 , to Nov. 9 , 19 59 , that I last saw the deceased alive on Nov. 9 , 19 59 , and that death occurred at 1:00a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar		M.D. SPRING GROVE STATE HOSPITAL		DATE SIGNED 11-9-59			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/12/59	22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE C. V. ...			ADDRESS 4611 Park Heights Ave		24a. REC'D BY REGISTRAR DATE NOV 10 1959	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2267

1894

Page One of

<p>1. Name of Deceased: <u>John A. Smith</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u> Years</p>		<p>4. Date of Birth: <u>Jan 15 1849</u></p>	
<p>5. Place of Birth: <u>England</u></p>		<p>6. Date of Death: <u>Dec 10 1894</u></p>	
<p>7. Cause of Death: <u>Heart Disease</u></p>		<p>8. Place of Death: <u>Home</u></p>	
<p>9. Signature of Physician: <u>John A. Smith</u></p>		<p>10. Signature of Registrar: <u>John A. Smith</u></p>	
<p>11. Signature of Coroner: <u>John A. Smith</u></p>		<p>12. Signature of Burial Officer: <u>John A. Smith</u></p>	
<p>13. Signature of Minister: <u>John A. Smith</u></p>		<p>14. Signature of Undertaker: <u>John A. Smith</u></p>	
<p>15. Signature of Family: <u>John A. Smith</u></p>		<p>16. Signature of Friends: <u>John A. Smith</u></p>	
<p>17. Signature of Church: <u>John A. Smith</u></p>		<p>18. Signature of Cemetery: <u>John A. Smith</u></p>	
<p>19. Signature of Burial: <u>John A. Smith</u></p>		<p>20. Signature of Interment: <u>John A. Smith</u></p>	
<p>21. Signature of Burial: <u>John A. Smith</u></p>		<p>22. Signature of Interment: <u>John A. Smith</u></p>	
<p>23. Signature of Burial: <u>John A. Smith</u></p>		<p>24. Signature of Interment: <u>John A. Smith</u></p>	
<p>25. Signature of Burial: <u>John A. Smith</u></p>		<p>26. Signature of Interment: <u>John A. Smith</u></p>	
<p>27. Signature of Burial: <u>John A. Smith</u></p>		<p>28. Signature of Interment: <u>John A. Smith</u></p>	
<p>29. Signature of Burial: <u>John A. Smith</u></p>		<p>30. Signature of Interment: <u>John A. Smith</u></p>	
<p>31. Signature of Burial: <u>John A. Smith</u></p>		<p>32. Signature of Interment: <u>John A. Smith</u></p>	
<p>33. Signature of Burial: <u>John A. Smith</u></p>		<p>34. Signature of Interment: <u>John A. Smith</u></p>	
<p>35. Signature of Burial: <u>John A. Smith</u></p>		<p>36. Signature of Interment: <u>John A. Smith</u></p>	
<p>37. Signature of Burial: <u>John A. Smith</u></p>		<p>38. Signature of Interment: <u>John A. Smith</u></p>	
<p>39. Signature of Burial: <u>John A. Smith</u></p>		<p>40. Signature of Interment: <u>John A. Smith</u></p>	
<p>41. Signature of Burial: <u>John A. Smith</u></p>		<p>42. Signature of Interment: <u>John A. Smith</u></p>	
<p>43. Signature of Burial: <u>John A. Smith</u></p>		<p>44. Signature of Interment: <u>John A. Smith</u></p>	
<p>45. Signature of Burial: <u>John A. Smith</u></p>		<p>46. Signature of Interment: <u>John A. Smith</u></p>	
<p>47. Signature of Burial: <u>John A. Smith</u></p>		<p>48. Signature of Interment: <u>John A. Smith</u></p>	
<p>49. Signature of Burial: <u>John A. Smith</u></p>		<p>50. Signature of Interment: <u>John A. Smith</u></p>	
<p>51. Signature of Burial: <u>John A. Smith</u></p>		<p>52. Signature of Interment: <u>John A. Smith</u></p>	
<p>53. Signature of Burial: <u>John A. Smith</u></p>		<p>54. Signature of Interment: <u>John A. Smith</u></p>	
<p>55. Signature of Burial: <u>John A. Smith</u></p>		<p>56. Signature of Interment: <u>John A. Smith</u></p>	
<p>57. Signature of Burial: <u>John A. Smith</u></p>		<p>58. Signature of Interment: <u>John A. Smith</u></p>	
<p>59. Signature of Burial: <u>John A. Smith</u></p>		<p>60. Signature of Interment: <u>John A. Smith</u></p>	
<p>61. Signature of Burial: <u>John A. Smith</u></p>		<p>62. Signature of Interment: <u>John A. Smith</u></p>	
<p>63. Signature of Burial: <u>John A. Smith</u></p>		<p>64. Signature of Interment: <u>John A. Smith</u></p>	
<p>65. Signature of Burial: <u>John A. Smith</u></p>		<p>66. Signature of Interment: <u>John A. Smith</u></p>	
<p>67. Signature of Burial: <u>John A. Smith</u></p>		<p>68. Signature of Interment: <u>John A. Smith</u></p>	
<p>69. Signature of Burial: <u>John A. Smith</u></p>		<p>70. Signature of Interment: <u>John A. Smith</u></p>	
<p>71. Signature of Burial: <u>John A. Smith</u></p>		<p>72. Signature of Interment: <u>John A. Smith</u></p>	
<p>73. Signature of Burial: <u>John A. Smith</u></p>		<p>74. Signature of Interment: <u>John A. Smith</u></p>	
<p>75. Signature of Burial: <u>John A. Smith</u></p>		<p>76. Signature of Interment: <u>John A. Smith</u></p>	
<p>77. Signature of Burial: <u>John A. Smith</u></p>		<p>78. Signature of Interment: <u>John A. Smith</u></p>	
<p>79. Signature of Burial: <u>John A. Smith</u></p>		<p>80. Signature of Interment: <u>John A. Smith</u></p>	
<p>81. Signature of Burial: <u>John A. Smith</u></p>		<p>82. Signature of Interment: <u>John A. Smith</u></p>	
<p>83. Signature of Burial: <u>John A. Smith</u></p>		<p>84. Signature of Interment: <u>John A. Smith</u></p>	
<p>85. Signature of Burial: <u>John A. Smith</u></p>		<p>86. Signature of Interment: <u>John A. Smith</u></p>	
<p>87. Signature of Burial: <u>John A. Smith</u></p>		<p>88. Signature of Interment: <u>John A. Smith</u></p>	
<p>89. Signature of Burial: <u>John A. Smith</u></p>		<p>90. Signature of Interment: <u>John A. Smith</u></p>	
<p>91. Signature of Burial: <u>John A. Smith</u></p>		<p>92. Signature of Interment: <u>John A. Smith</u></p>	
<p>93. Signature of Burial: <u>John A. Smith</u></p>		<p>94. Signature of Interment: <u>John A. Smith</u></p>	
<p>95. Signature of Burial: <u>John A. Smith</u></p>		<p>96. Signature of Interment: <u>John A. Smith</u></p>	
<p>97. Signature of Burial: <u>John A. Smith</u></p>		<p>98. Signature of Interment: <u>John A. Smith</u></p>	
<p>99. Signature of Burial: <u>John A. Smith</u></p>		<p>100. Signature of Interment: <u>John A. Smith</u></p>	

1894

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12268

CERTIFICATE OF DEATH

Reg. Dist. No.

12242

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jacob Middle Graff Last Graff		4. DATE OF DEATH Month 11 Day 27 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/18/98
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 11 Days 27 Hours 19 Min. 59	11. IF UNDER 24 HRS. Months 11 Days 27 Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jacob Graff	
14. MOTHER'S MAIDEN NAME Barbara Schmidt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. —		INFORMANT Rosewood Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of stomach content and focal broncho pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491X (c) 491X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter W. Rieckert		ADDRESS (Street, city or town, state) Baltimore 14, Md	
PHYSICIAN'S NAME (Type) Peter W. Rieckert		DATE SIGNED 11/27/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/30/59	22c. NAME OF CEMETERY OR CREMATORY Parkwood	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home		ADDRESS 4210 Belair Road	
24a. REC'D BY REGISTRAR DEC 1 59		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

STATE OF TEXAS
DEPARTMENT OF HEALTH

12243

12243

DEATH CERTIFICATE

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH.

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

Signature of Physician

Signature of Informant

Signature of Registrar

FILED IN

DATE

OFFICE OF THE REGISTRAR

STATE OF TEXAS

12269

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
c. LENGTH OF STAY IN 1b <u>45yrs4mth11dys</u>				2103-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>Hagerstown, Md.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Effie</u> Middle <u>S.</u> Last <u>Groshon</u>		4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1959</u>					
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 14, 1877</u>	9. AGE (In years last birthday) yrs. <u>82</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>factory worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Jasper Groshon</u>				14. MOTHER'S MAIDEN NAME <u>Alice Weddell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the rectum</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) <u></u>	(County) <u></u>	(State) <u></u>		
21. I certify that I attended the deceased from <u>April 1</u> , 19 <u>59</u> , to <u>Nov. 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 19</u> , 19 <u>59</u> , and that death occurred at <u>7:15a</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				DATE SIGNED <u>11-19-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-22-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Creagerstown Cem.</u>	22d. LOCATION (City, town, or county) <u>Creagerstown, Md.</u>	(State) <u></u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>				ADDRESS <u>Thurmont, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 23 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12270
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED ☐ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

151X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Complete debilitation

Carcinomatosis

Gastric Adenocarcinoma

INTERVAL BETWEEN ONSET OF DEATH

4 mos.

18 mos.

18 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

cardiac asthma

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month Day Year
Hour a. m. p. m. 1920d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Nov. 16, 1957, to Nov. 19, 1959, that I last saw the deceased alive on Nov. 16, 1957, and that death occurred at 8:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE

Frank T. Kasik Jr.

M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

9005 Hartford Rd

11/17/59

PHYSICIAN'S NAME (Type)

FRANK T. KASIK JR. BALTO 14 MD

22a. BURIAL, CREMATION, or other disposal (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

CHAR. F. EVANS & SON

8802 HARTFORD RD

DATE NOV 19 '59

Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1954

1954

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>MALE</i>		3. AGE <i>68</i>		4. DATE OF BIRTH <i>1900</i>		5. PLACE OF BIRTH <i>NEW YORK</i>		6. OCCUPATION <i>RETIRED</i>	
7. MARITAL STATUS <i>MARRIED</i>		8. RACE <i>WHITE</i>		9. RELIGION <i>CATHOLIC</i>		10. EDUCATION <i>HIGH SCHOOL</i>		11. SOCIAL SECURITY NUMBER <i>1-234-567890</i>		12. PLACE OF DEATH <i>HOME</i>	
13. DATE OF DEATH <i>1954</i>		14. TIME OF DEATH <i>10:00 AM</i>		15. CAUSE OF DEATH <i>HEART DISEASE</i>		16. MANNER OF DEATH <i>NATURAL</i>		17. PLACE OF INTERMENT <i>CATHOLIC CHURCH</i>		18. NAME OF MINISTER <i>JOHN J. BROWN</i>	
19. SIGNATURE OF DECEASED <i>JOHN J. BROWN</i>		20. SIGNATURE OF WITNESS <i>JOHN J. BROWN</i>		21. SIGNATURE OF DECEASED <i>JOHN J. BROWN</i>		22. SIGNATURE OF WITNESS <i>JOHN J. BROWN</i>		23. SIGNATURE OF DECEASED <i>JOHN J. BROWN</i>		24. SIGNATURE OF WITNESS <i>JOHN J. BROWN</i>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18.

CERTIFICATE OF DEATH

Reg. Dist. No.

12245

12271

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 48 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE (16) 3V01-4	
f. STREET ADDRESS 1817 ASHBURTON STREET		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle S. Last HALL		4. DATE OF DEATH Month November Day 23 Year 1959	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-9-1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEVEDORE		10b. KIND OF BUSINESS OR INDUSTRY SHIPPING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISAAC HALL		14. MOTHER'S MAIDEN NAME MARY DIGGS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 217-03-0091	
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION		Address FT HOWARD DIVISION	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS WITH METASTASES TO PERICARDIUM, MYOCARDIUM, LUNGS, DIAPHRAGM AND PERITRACHEAL, PERIAORTIC AND HILAR LYMPH AND LYMPH NODES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LYMPH NODES (c) CHRONIC PASSIVE CONGESTION OF LUNG, LIVER AND SPLEEN.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC PASSIVE CONGESTION OF LUNG, LIVER AND SPLEEN.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 6, 1959 to November 23, 1959 and that death occurred at 4:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) BALTIMORE VAH, FT. HOWARD DIVISION MD DATE SIGNED 11/24/59			
ACTUAL SIGNATURE John W. Crawford		M.D. BALTIMORE VAH, FT. HOWARD DIVISION	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH, BALTO. 18, MD. FT. HOWARD DIVISION	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/27/59	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Charles A Rice Funeral		24a. REC'D BY REGISTRAR DATE NOV 25 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12345

CERTIFICATE OF DEATH

12345



12272

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2yr2mth23dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>940 Ashland Court</u>	
3. NAME OF DECEASED (Type or print) First <u>Benson</u> Middle <u>Cornelius</u> Last <u>Hardesty</u>		4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1870</u>
9. AGE (In years last birthday) yrs. <u>89</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Hardesty</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive Heart Failure</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October 30, 1959</u> , to <u>Nov. 24, 1959</u> , that I last saw the deceased alive on <u>Nov. 24, 1959</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D. <u>SPRING GROVE STATE HOSPITAL</u> <u>11/24/1959</u> PHYSICIAN'S NAME (Type) <u>BRUNO RADAUSKAS</u> <u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickner & Sons - Bacto 17</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 27 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

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12197
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 8 Film G251 11/12/59 iwk
CERTIFICATE OF DEATH

12247

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Turner Statino		c. LENGTH OF STAY IN 1b 55yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 201 Ash Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ida Middle M. Last Harris		4. DATE OF DEATH Month November Day 4 Year 1959	
5. SEX F	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1879 1870
9. AGE (In years last birthday) yrs. 89		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Lawrenceville, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Beryl Franklin		14. MOTHER'S MAIDEN NAME Sarah Franklin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Ida M. Drewitt, 201 Ash Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension + arterio sclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH NOV 4-59 unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. _____ p. m. 12		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1957 to November 4, 1959 , that I last saw the deceased alive on November 4, 1959 , and that death occurred at P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 107 N. Main St. Baltimore Md. DATE SIGNED Nov 9 '59			
ACTUAL SIGNATURE [Signature]		M.D. [Signature]	
PHYSICIAN'S NAME (Type) [Signature]			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/7/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) A.A. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law, 802 Madison Ave.		24a. REC'D BY REGISTRAR DATE NOV 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

STATE DEPARTMENT OF HEALTH—BATHING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12273

CERTIFICATE OF DEATH

12248

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN ARM</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X GLEN ARM.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT #1 Box 640 GLEN ARM ROAD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence Thomas Hayes</u>				4. DATE OF DEATH Month Day Year <u>Nov. 28 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 16, 1895</u>		9. AGE (In years last birthday) <u>64</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JEROME HAYES.</u>				14. MOTHER'S MAIDEN NAME <u>CARRIE UNKNOWN.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>218-03-3894</u>		17. INFORMANT Address <u>LORETTA V HAYES RT #1 Box 640 RD. GLEN ARM</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion - infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <u>Arteriosclerotic CVD</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 24, 1959</u> to <u>Nov. 28, 1959</u> , that I last saw the deceased alive on <u>Nov. 24, 1959</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William G. Tyson</u> M.D.				DATE SIGNED <u>Nov. 28, 1959</u>			
PHYSICIAN'S NAME (Type) <u>Clifford F. Hudson</u>				seen by me at time of <u>death</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC 1, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home 7401 Belair Rd Balt</u>				24a. REC'D BY REGISTRAR <u>DEC 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12373

NAME OF DECEASED JAMES A. WILSON		DATE OF DEATH JAN 15 1944	
AGE 68		SEX M	
RACE W		RELIGION M	
MARRIED Y		OCCUPATION RETIRED	
PLACE OF BIRTH BALTIMORE, MD		PLACE OF DEATH BALTIMORE, MD	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. WILSON		SIGNATURE OF REGISTRAR J. H. WILSON	
DATE OF SIGNATURE JAN 15 1944		DATE OF SIGNATURE JAN 15 1944	

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12274

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12249

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5915 Robindale Rd.</u>				d. STREET ADDRESS <u>5915 Robindale Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>FRANKLIN</u> Middle <u>C.</u> Last <u>HECK</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>18</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 21, 1887</u>	
9. AGE (In years lost birthday) yrs. <u>72</u>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant (rtd)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale Drugs</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>George Heck</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Pinschmidt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mrs. Helen Heck - 5915 Robindale Rd., Ctnsvle</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, Acute</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>unknown</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July</u> , 19 <u>59</u> , to <u>Nov.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 16</u> , 19 <u>59</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1 Mallow Hill Ave., Baltimore 29, Maryland.</u> DATE SIGNED <u>11/20/59</u>							
ACTUAL SIGNATURE <u>Leo J. Gaver</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Leo J. Gaver</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner & Sons - Balto</u> <u>17 Md</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. Tickner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1934



STATE OF NEW YORK
DEPARTMENT OF HEALTH
OFFICE OF THE STATE REGISTRAR

Blank form with horizontal lines for text entry.

12275

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Middleborough, Balto. Co. MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland			b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middleborough, Essex, Md.			c. LENGTH OF STAY IN 1b 54 Middleborough, Essex, Maryland			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 314 West Road			d. STREET ADDRESS 314 West Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Genevieve Marie Heil			4. DATE OF DEATH Month Day Year November 28 1959							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 8, 1900		9. AGE (In years last birthday) 59 yrs.		
						IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Retired			11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dennis O'Connell					14. MOTHER'S MAIDEN NAME Catherine Buberl					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No			16. SOCIAL SECURITY NO. 213-20-3104		17. INFORMANT Genevieve Schub				Address 7714 Gough St. Balto. 24	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 446x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nephrosclerosis DUE TO (c) Generalized arteriosclerosis									INTERVAL BETWEEN ONSET AND DEATH 4 wks. Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb 1958, to 11/28, 1959, that I lost the deceased olive on 11/27, 1959, and that death occurred at 10:15 A.M. from the causes and on the date stated above.										
ACTUAL SIGNATURE J. Platt			M.D. 424 Eastern Ave.			ADDRESS (Street, city or town, state) Essex, Md.			DATE SIGNED 11/30/59	
PHYSICIAN'S NAME (Type) J. PLATT, M.D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 12-1-59		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer			22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE A. Christine Brydzinski					ADDRESS 1407 Eastern		24a. REC'D BY REGISTRAR DATE DEC 1 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Krane	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12251

12276

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton RD #1</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Georges Creek Rd</u>				d. STREET ADDRESS <u>Georges Creek Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Mary</u> Last <u>Heiss</u>				4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 15 1885</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Edward Royston</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Shearer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Claude Heiss, Parkton Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May 12, 1954</u> , to <u>Nov 21, 1959</u> , that I last saw the deceased alive on <u>Nov 16, 1959</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u>				ADDRESS (Street, city or town, state) <u>Hampstead Md</u>			
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				DATE SIGNED <u>11-21-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Middletown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Freeland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Eric Fortenstein</u>				ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 24 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>			

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12277

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown c. LENGTH OF STAY IN 1b Randallstown d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3605 Stoneybrook Rd.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown d. STREET ADDRESS 3605 Stoneybrook Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First ARTHUR Middle W. HELINE Last 4. DATE OF DEATH Month Nov. Day 26, Year 19 59				5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Mar. 9, 1901 9. AGE (In years last birthday) 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Work				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? .	
13. FATHER'S NAME John Henry Heline				14. MOTHER'S MAIDEN NAME - Miller					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no		INFORMANT Address Mrs. Norma E. Heline-3605 Stoneybrook Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO (b) PREMATURE ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 16 MINUTES								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/10, 1958 to 11/26, 1959 that I last saw the deceased alive on 11/24, 1959 , and that death occurred at 8:24 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 8204 LIBERTY RD. BALTO. 7 MD 11/28/59 ACTUAL SIGNATURE Edwin L. Pierpont M.D. PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11/30/59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Baltor						24a. REC'D BY REGISTRAR DATE NOV 30 '59		24b. REGISTRAR'S SIGNATURE William S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained at the hospital or attending physician.
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15253

CERTIFICATE OF DEATH

15253



CERTIFICATE OF DEATH

12253

Reg. Dist. No.

12278

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1104 BAKER AVE.</u>				d. STREET ADDRESS <u>1104 BAKER AVE.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>IVANA - HENIGMAN</u>				4. DATE OF DEATH Month Day Year <u>NOV. 5 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 15, 1877</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOSEPH RAUNIKAR</u>				14. MOTHER'S MAIDEN NAME <u>AGNES CHERNICK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Rudolph H. Henigman - 1104 Baker Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Pyelonephritis</u> DUE TO (c) <u>20 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/1</u> , 19 <u>58</u> , to <u>11/5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/3</u> , 19 <u>59</u> , and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-7-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Goble Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Foley Funeral Home - Catonsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12279

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Baltimore (Halethorpe)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4603 Lincoln Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Georgia G. Middle Henry Last				4. DATE OF DEATH Month November Day 21 Year 1959			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1883	9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U'S.A.	
13. FATHER'S NAME William R. Gillingham				14. MOTHER'S MAIDEN NAME Georgiana G. McCoy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Donald D. Henry 1233 Circle Drive #27		INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Moderate Hypertension DUE TO ✓ (c)							INTERVAL BETWEEN ONSET AND DEATH sudden + weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 18, 1959 to Nov 21, 1959 that I last saw the deceased alive on Nov 18, 1959 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Frederick Beitler				ADDRESS (Street, city or town, state) M.D. 1014 Francis Avenue Baltimore 27 - Nov 23-59			
PHYSICIAN'S NAME (Type) Frederick Beitler, M.D.				1014 Francis Avenue #27			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-24-59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Avenue				24a. REC'D BY REGISTRAR NOV 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kinas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12334

CERTIFICATE OF DEATH

12334

Baltimore

Id.

Baltimore

Baltimore (Halethorpe)

Baltimore

1603 Lincoln Drive

1603 Lincoln Drive

November 21, 1958

Georgia G. Henry

April 11, 1883 76

female white xxx

U.S.A.

Maryland

Housewife

Georgiana G. McCoy

William R. Callingham

Donald D. Henry 1233 Circle Drive 27

no

1014 Francis Avenue 27

Frederick Belter, M.D.

Baltimore, Maryland

Funeral 11:30 AM London Park Cem.

Howard H. Hubbard 4107 Wilkins Avenue

12280

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>3001-4</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>None</i> 7		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <i>Essex Rd. (Villa Nova)</i> <i>Robb Nursing Home</i>		d. STREET ADDRESS <i>2524 Druid Park Drive</i>	
3. NAME OF DECEASED (Type or print) <i>Rosswell</i> First <i>G.</i> Middle <i>High</i> Last		4. DATE OF DEATH Month <i>Nov</i> Day <i>9</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 27, 1885</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steam Fitter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>--</i>	9. AGE (In years last birthday) <i>74</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Rosswell Grover High</i>		14. MOTHER'S MAIDEN NAME <i>Georgianna ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>215-09-2892</i>	
17. INFORMANT <i>Mr. Frank G. Hite - 3504 Greenspring Ave.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intermittent C.V.D.</i> 442X DUE TO <i>Nephritis, chronic</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Prostatic hypertrophy</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Variococcal abscess</i>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept 21</i> , 1957, to <i>Nov 7</i> , 1959, that I last saw the deceased alive on <i>Nov 8</i> , 1959, and that death occurred at <i>4:10 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles H. Williams</i> M.D.		ADDRESS (Street, city or town, state) <i>1632 Reisterstown Road</i>	
PHYSICIAN'S NAME (Type) <i>Charles H. Williams</i>		DATE SIGNED <i>Pikesville 8, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/13/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Woodlawn, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sam. G. Lickner & Sons - Balt 17</i>		ADDRESS <i>md</i>	
24a. REC'D BY REGISTRAR <i>NOV 12 '59</i>		24b. REGISTRAR'S SIGNATURE <i>William G. Kenna</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1920

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12256

12281

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>52 CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NURSING HOME - 3 ROBERTS AVE.</u>		d. STREET ADDRESS <u>6120 BALTO. NAT'L PIKE</u>	
3. NAME OF DECEASED (Type or print) First <u>ESTELLA</u> Middle <u>D.</u> Last <u>HILL</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 31, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>COLUMBUS, GA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>JOSHUA DILLARD</u>	
14. MOTHER'S MAIDEN NAME <u>HARRIETT</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>6102</u> <u>MRS. BEulah H. JACKSON BALTO. NAT'L PIKE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arterio-sclerotic Heart</u> DUE TO (c) <u>Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 15th, 1959</u> , to <u>Nov. 1st, 1959</u> , that I last saw the deceased alive on <u>Nov. 1st, 1959</u> , and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. F. Maloney M.D.</u>		ADDRESS (Street, city or town, state) <u>57 Winters Lane II/2/59</u>	
PHYSICIAN'S NAME (Type) <u>C. F. Maloney, M.D.</u>		DATE SIGNED <u>II/2/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>NOV. 5, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LINCOLN MEM.</u>	22d. LOCATION (City, town, or county) (State) <u>WASH. D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halland Funeral Home</u>		ADDRESS <u>1631</u>	24a. REC'D BY REGISTRAR DATE <u>NOV 5 '59</u>
24b. REGISTRAR'S SIGNATURE <u>C. F. Maloney</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57

CERTIFICATE OF DEATH

RECORDED

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Nature of disease		8. Duration of illness	
9. Name of physician		10. Name of attending physician		11. Name of funeral director		12. Name of undertaker	
13. Name of informant		14. Name of witness		15. Name of registrar		16. Name of registrar	
17. Name of registrar		18. Name of registrar		19. Name of registrar		20. Name of registrar	
21. Name of registrar		22. Name of registrar		23. Name of registrar		24. Name of registrar	
25. Name of registrar		26. Name of registrar		27. Name of registrar		28. Name of registrar	
29. Name of registrar		30. Name of registrar		31. Name of registrar		32. Name of registrar	
33. Name of registrar		34. Name of registrar		35. Name of registrar		36. Name of registrar	
37. Name of registrar		38. Name of registrar		39. Name of registrar		40. Name of registrar	
41. Name of registrar		42. Name of registrar		43. Name of registrar		44. Name of registrar	
45. Name of registrar		46. Name of registrar		47. Name of registrar		48. Name of registrar	
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61. Name of registrar		62. Name of registrar		63. Name of registrar		64. Name of registrar	
65. Name of registrar		66. Name of registrar		67. Name of registrar		68. Name of registrar	
69. Name of registrar		70. Name of registrar		71. Name of registrar		72. Name of registrar	
73. Name of registrar		74. Name of registrar		75. Name of registrar		76. Name of registrar	
77. Name of registrar		78. Name of registrar		79. Name of registrar		80. Name of registrar	
81. Name of registrar		82. Name of registrar		83. Name of registrar		84. Name of registrar	
85. Name of registrar		86. Name of registrar		87. Name of registrar		88. Name of registrar	
89. Name of registrar		90. Name of registrar		91. Name of registrar		92. Name of registrar	
93. Name of registrar		94. Name of registrar		95. Name of registrar		96. Name of registrar	
97. Name of registrar		98. Name of registrar		99. Name of registrar		100. Name of registrar	

1

12282

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12257

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PARKVILLE</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2935 North Wind Rd.</i>		d. STREET ADDRESS <i>2935 North Wind Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Harry</i> Middle <i>J.</i> Last <i>Holland</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>14,</i> Year <i>1959</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-18-1876</i>
9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Elevator Cont.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Penna.</i>	11. BIRTHPLACE (State or foreign country) <i>USA</i>
13. FATHER'S NAME <i>John Holland</i>		14. MOTHER'S MAIDEN NAME <i>Delhea Clancey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Margaret J. Holland</i> Address <i>same</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>carcinoma of Prostate</i> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1949</i> , 19 <i>Nov 14</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Nov 14</i> , 19 <i>59</i> , and that death occurred at <i>7:48</i> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Harold H. Burns</i>		ADDRESS (Street, city or town, state) <i>8106 Harford Rd.</i> DATE SIGNED <i>11-16-59</i>	
PHYSICIAN'S NAME (Type) <i>Harold H. Burns</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>11-18-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Rd.</i>	
24a. REC'D BY REGISTRAR DATE <i>NOV 18 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12283 CERTIFICATE OF DEATH

1. NAME OF DECEASED
(Type or Print)

Ellsworth A. Hurlock

2. DATE OF DEATH
Reg. Dist. No.

November 8, 1959

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore City County

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE 212 Gaywood Road - Baltimore 12

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 12D. STREET ADDRESS (If rural, give location)
212 Gaywood Road

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

May 30, 1893

9. AGE (In years last birthday)

66

If Under 1 Year

Months

Days

If Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman10B. KIND OF BUSINESS OR INDUSTRY
Auto. parts

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
U.S.A.

13. FATHER'S NAME

Elmer E. Hurlock

14. MOTHER'S MAIDEN NAME

Mary I. Allen

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
YES W.W.II16. SOCIAL SECURITY NO.
212-07-4795

17. INFORMANT

ADDRESS

Alice K. Hurlock, 212 Gaywood Road

18.

334X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)(A) Hemiplegia left April 1959
DUE TO right Sept 27, 1959

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Vascular Disease 3 yrs
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Decubitus Ulcers & Eczema

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

21D. TIME (Month) (Day) (Year) Hour OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

YES ☐ NO ☒

22. I certify that (I) (this hospital) attended the deceased from 10/29/59 to 11/8/59, that (I) (we) last saw the deceased alive on 11/8/59, and that in (my) (our) opinion death occurred at 12:35 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Wm. Cook-Towson

23B. ADDRESS

8358 Loch Raven Blvd #4

23C. DATE SIGNED

11/9/59

ATTENDING PHYS. ☒MED. DIRECTOR ☐STAFF PHYS. ☐

M.D.

24A. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL

24B. DATE

11-11-59

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cemetery

24D. LOCATION (City, town, or county) (State)

Pikesville

DATE RECEIVED BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Towson, Inc., 1050 York Road

THIS IS A PERMANENT RECORD

PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN
Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

S CERTIFICATE MUST BE FILTH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12284

CERTIFICATE OF DEATH

12259

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> 0210-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sheppard Pratt Hosp.</u>		d. STREET ADDRESS <u>225 Westwood Rd, Wardour</u>	
3. NAME OF DECEASED (Type or print) First <u>Amos</u> Middle <u>Francis</u> Last <u>Hutchins</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 28, 1884</u> 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Surgeon</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Love Hutchins</u>		14. MOTHER'S MAIDEN NAME <u>Anna Mary Bowen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> 1917-19		16. SOCIAL SECURITY NO. <u>Hosp. Records</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>34yr +</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome due to Cerebral Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 23, 1959</u> , to <u>Nov 11, 1959</u> , that I last saw the deceased alive on <u>Nov 11, 1959</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. W. Elgin</u>		DATE SIGNED <u>Nov. 11, 1959</u>	
PHYSICIAN'S NAME (Type) <u>W. W. Elgin</u>		M.D. <u>Sheppard Pratt Hosp. Towson 4, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-14-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Dryden Ridge Cont</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Saylor Sons</u>		ADDRESS <u>Annapolis Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Chisholm & Kraus</u>	
DATE NOV 16 '59			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DE 11.2 A
FAC CONTENT

MINOR OFFENSE

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
1982
CERTIFICATE OF DEATH

1. NAME OF DECEASED John Doe	
2. SEX Male	
3. AGE 65	
4. DATE OF BIRTH 11/15/1917	
5. PLACE OF BIRTH Baltimore, Maryland	
6. OCCUPATION Retired	
7. MARITAL STATUS Married	
8. DATE OF DEATH 11/15/1982	
9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Heart Disease	
11. MANNER OF DEATH Natural	
12. SIGNATURE OF PHYSICIAN [Signature]	
13. SIGNATURE OF REGISTRAR [Signature]	
14. SIGNATURE OF DECEASED [Signature]	
15. SIGNATURE OF WITNESS [Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12260

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest (Sparrows Point)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Lodge Forest				d. STREET ADDRESS 2114 Oak Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jacob Middle Isaacson Last 				4. DATE OF DEATH Month Nov Day 2 Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 15 1887		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beth Steel Mill ret		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Finland		12. CITIZEN OF WHAT COUNTRY? U S	
13. FATHER'S NAME Isaacson Isaacson				14. MOTHER'S MAIDEN NAME Marie ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 213-09-3959		17. INFORMANT Address Mrs Martha Isaacson 2114 Oak Road Lodge Forest			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) 						INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-3-59	
EXAMINER'S NAME (Type) Jack C Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF Nov 5/59	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore County			
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave;				24a. REC'D BY REGISTRAR DATE NOV 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

12286

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 3V01-4 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 637 Stirling Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELIJAH ----- JACKSON		4. DATE OF DEATH Month Day Year November 1 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1898
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	
11. BIRTHPLACE (State or foreign country) Drakes Branch, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Jackson		14. MOTHER'S MAIDEN NAME Mary Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 217 07 2736	
17. INFORMANT Clin. Rec., VAH Balto 18, Md. Ft. Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) CERE BRO-VASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) HYPERTENSION DUE TO (c) Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS; LEFT MIDDLE CEREBRAL ARTERY THROMBOSIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from October 25, 1959 to November 1, 1959 and that death occurred at 2:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH Balto., Md. Ft. Howard Div. 11/1/59 ACTUAL SIGNATURE S. J. MANGUS, M.D. PHYSICIAN'S NAME (Type) VAH Balto., Md. Ft. Howard Div. 11/1/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-5-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson		24a. REC'D BY REGISTRAR NOV 2 '59	
24b. REGISTRAR'S SIGNATURE Calvin E. Hines			

ELROY O. WILSON, 2004 ORLEANS ST., BALTO., MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10591

12287

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 48 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore(13) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore(13) d. STREET ADDRESS 2028 Llewellyn Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE --- JACKSON		4. DATE OF DEATH Month Day Year November 19 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1884
9. AGE (In years last birthday) 75		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Barnesville, Virginia	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Jackson		14. MOTHER'S MAIDEN NAME Elie Washington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 217-01-9851	
17. INFORMANT Clinical Records, VAH, Balto. 18, Md., Ft. Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EDEMA OF THE LUNGS 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of stomach with metastases to the liver, periaortic and peritracheal lymph nodes.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 2, 1959 to November 19, 1959 and that death occurred at 8:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO. 18, MD. FORT HOWARD DIVISION DATE SIGNED n 11/19/59			
ACTUAL SIGNATURE John W. Crawford		M.D. J. W. Crawford	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH, BALTO. 18, MD. FORT HOWARD DIVISION	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/23/59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St. Baltimore 17, Md.		24a. REC'D BY REGISTRAR NOV 24 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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VA

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12281

(Signature)

10/1/1918

Attest: Registrar

10/1/1918

Registrar

(Signature)

10/1/1918

Attest: Registrar

10/1/1918

Attest: Registrar

Attest: Registrar

Attest: Registrar

Attest: Registrar

Attest: Registrar

Attest: Registrar

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12263

12288

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rodgers Forge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>148 Hopkins Rd.</u>				d. STREET ADDRESS <u>148 Hopkins Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>GERARD</u> Last <u>JENKINS</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>20</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 30, 1956</u>	
9. AGE (In years lost birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.		IF UNDER 24 HRS. Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Md.</u>							
13. FATHER'S NAME <u>J. Calvin Jenkins</u>				14. MOTHER'S MAIDEN NAME <u>Sally Brady</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
INFORMANT <u>Mr. J. Calvin Jenkins - 148 Hopkins Rd. #12</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute lymphatic leukemia</u> 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>59</u> , to <u>Nov. 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 17</u> , 19 <u>59</u> , and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Milton S. Sacks</u> M.D.				ADDRESS (Street, city or town, state) <u>University Hospital</u> DATE SIGNED <u>—</u>			
PHYSICIAN'S NAME (Type) <u>MILTON S. SACKS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Sackner & Sons - Balto</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>NOV 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

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12200

CERTIFICATE OF DEATH

12200



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12264

12289

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 0210-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 110 Prince George Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GROVER Middle P. Last JOHNSON		4. DATE OF DEATH Month November Day 25 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 18, 1907
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY State of Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Goldsborough Johnson		14. MOTHER'S MAIDEN NAME Augusta Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 214-07-7922	
INFORMANT Clin. Records. VAH, Balto. Md. Ft. Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) CORONARY OCCLUSION DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 2 Plus Dys.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Old Myocardial Infarction due to Corronary Occlusion. 2. Edema of Lungs. 3. Gout with Multiple Tophi.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VS attended the deceased from November 11, 19 59 to November 25, 19 59 and that death occurred at 6:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Crawford		DATE SIGNED VAH, BALTIMORE, MD. FT HOWARD DIV 11/25/59	
PHYSICIAN'S NAME (Type) J OHN W. CRAWFORD, M.D.		VAH, BALTO., MD. FT HOWARD DIV 11/25/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/27/59	
22c. NAME OF CEMETERY OR CREMATORY Episcopal Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Home, Cambridge, Maryland		24a. REC'D BY REGISTRAR NOV 27 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Charles S. K...	

CERTIFICATE OF DEATH

1922



1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Place of death: _____

8. Cause of death: _____

9. Signature of physician: _____

10. Signature of registrar: _____

11. Signature of informant: _____

12. Name of informant: _____

13. Address of informant: _____

14. Date of completion: _____

15. Registrar's office: _____

16. County: _____

17. State: _____

18. City: _____

19. Zip: _____

20. Telephone: _____

21. Fax: _____

22. E-mail: _____

23. Website: _____

24. Social media: _____

25. Other: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12198

CERTIFICATE OF DEATH

12263

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8024 Norris Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucael Middle Johnson Last Johnson		4. DATE OF DEATH Month November Day 20 Year 19 59	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April-19th.-1903
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min. 56	IF UNDER 24 HRS. Months 56 Days 56 Hours 56 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Essex County Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James R. Moulton		14. MOTHER'S MAIDEN NAME Fannie Payne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Horbert Johnson 8024 Norris Road Dundalk Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Stomach DUE TO (c) unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 4/59 to Nov 21/59 , that I last saw the deceased alive on Nov 21/59 , and that death occurred at 12 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. H. Thomas		ADDRESS (Street, city or town, state) 107 N. Main St. Balto 22 Md	
PHYSICIAN'S NAME (Type) J. H. Thomas		DATE SIGNED 11/21/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/24/59	22c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetary	22d. LOCATION (City, town, or county) (State) Brooklyn Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Elroy Nelson - 1000 Brantley Ave. Baltimore		24. REG'D BY REGISTRAR NOV 23 59	
ADDRESS 1000 Brantley Ave. Baltimore		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12193

12961

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1900		BALTIMORE, MARYLAND	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH	
Carpenter		Heart Disease		Natural		Home		JAN 20 1945	
EDUCATION		RELIGION		RACE		COLOR		MARITAL STATUS	
High School		Roman Catholic		White		White		Married	
PREVIOUS ILLNESS		TREATMENT		HISTORY OF DRUGS		HISTORY OF ALCOHOL		HISTORY OF TOBACCO	
None		None		None		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE		TIME		PLACE		CITY		STATE	
JAN 20 1945		10:00 AM		Home		BALTIMORE		MARYLAND	

RECEIVED
JAN 21 1945

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12290

CERTIFICATE OF DEATH

Reg. Dist. No.

12266

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 294 Cowenton Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Edward Last Kahl		4. DATE OF DEATH Month November Day 21 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6 Days 7 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Kahl		14. MOTHER'S MAIDEN NAME Mary Furnkas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-34-6664	
17. INFORMANT Mrs. Theresa Kahl		Address Box 294 Cowenton Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO ANGINA PECTORIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO HYPERTENSIVE CARDIOVASC. DIS. (b) Ch. Hypertrophic polyarthritis (c) Ch. Hypertrophic polyarthritis			INTERVAL BETWEEN ONSET AND DEATH 10 Min. 2 yrs. 15 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ch. Hypertrophic polyarthritis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 4:20 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/20 , 19 53 , to 11/21 , 19 59 , that I last saw the deceased alive on Nov. 19 , 19 59 , and that death occurred at 3:55 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clifford F. Hudson		ADDRESS (Street, city or town, state) FORK, MD.	
PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 24, 1959	
22c. NAME OF CEMETERY OR CREMATORY St. Joseph's		22d. LOCATION (City, town, or county) (State) Fullerton Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Laverne D. Home 7401 18th Rd.		24. REC'D BY REGISTRAR NOV 25 '59	
24b. REGISTRAR'S SIGNATURE Clifford F. Hudson			

13380

CERTIFICATE OF DEATH

13380

WILLIAM STANLEY KING OF LONDON - BIRTH



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12267

12291

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2810 Taylor Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>L. Kilchenstein</i> Last <i></i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>18</i> Year <i>19 59</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-12-1900</i>
9. AGE (In years last birthday) yrs. <i>59</i>		10. IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Grocery</i>	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>FRANK C. KILCHENSTEIN</i>		14. MOTHER'S MAIDEN NAME <i>ADELAID E. MACKINSON</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>213-26-4340</i>	
17. INFORMANT <i>Mary M. Kilchenstein</i>		Address <i>same</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Coronary occlusion</i> DUE TO <i>arteriosclerotic hypertension & chronic nephritis</i> DUE TO <i>Previous coronary occlusion 1958</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 min.</i> <i>15 years</i>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Poliomyelitis in infancy</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <i>Nov. 18, 1959</i> to <i>Nov. 18, 1959</i> , that I last saw the deceased alive on <i>Nov. 18, 1959</i> , and that death occurred at <i>14:20 M.</i> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>A. M. Bacon</i>	ADDRESS (Street, city or town, state) <i>2810 Taylor Ave. Baltimore 14 Md.</i>
PHYSICIAN'S NAME (Type) <i>A. M. BACON</i>	DATE SIGNED <i>Md.</i>

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>11-21-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 20 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kram</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1938

STATE OF TEXAS

1938



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12292

CERTIFICATE OF DEATH

Reg. Dist. No.

12268

1. PLACE OF DEATH a. COUNTY BALTIMORE COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8827 VICTORY AVE.		d. STREET ADDRESS 18827 VICTORY AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PRISCILLA L. KIPP		4. DATE OF DEATH NOV 25 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 8, 1873
9. AGE (In years last birthday) 85		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME REUBEN REHRIG		14. MOTHER'S MAIDEN NAME EMELINE RUCH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT WINNIE KIPP Address 8827 VICTORY AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO arteriosclerotic CardioVascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 yrs (c) 10 yrs		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1959 , to Nov 24, 1959 , that I last saw the deceased alive on Nov 24, 1959 , and that death occurred at 116 M , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. M. Baumgardner, M.D.		ADDRESS (Street, city or town, state) Baltimore Md DATE SIGNED 11/25/59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV 29, 1959	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) PENNSYLVANIA	
23. FUNERAL DIRECTOR'S SIGNATURE Jessaln. Funeral Home ADDRESS 7401 BELAIR RD.		24a. REC'D BY REGISTRAR NOV 30 '59 24b. REGISTRAR'S SIGNATURE Arthur S. House	

12308

CERTIFICATE OF DEATH

12308

RECEIVED
MAY 19 1964

[Faint, illegible text, likely a death certificate form with fields for name, date, and location.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12293

CERTIFICATE OF DEATH

Reg. Dist. No. 12269

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Reisterstown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Reisterstown</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Bryman's Lane</i>	
3. NAME OF DECEASED (Type or print) <i>CARL JACOB KLINGELHOFER</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>22</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 4, 1887</i>
9. AGE (In years last birthday) <i>72</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Finisher</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Adolph Klingelhofer</i>		14. MOTHER'S MAIDEN NAME <i>Mary Wess</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-03-3669</i>	
17. INFORMANT <i>Mrs. Susan Klingelhofer - wife</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.1 Congestive Heart Disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>11/22/1959</i> to <i>11/23/1959</i> , that I last saw the deceased alive on <i>11/22/1959</i> , and that death occurred at <i>9 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wm. E. Martin</i>		DATE SIGNED <i>Nov 30 1959</i>	
PHYSICIAN'S NAME (Type) <i>Wm. E. Martin</i>		ADDRESS (Street, city or town, state) <i>Randallstown, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-25-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Family</i>	22d. LOCATION (City, town, or county) (State) <i>Holbrook, Buld. Co., Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Knight - Sykesville, Md.</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1934

UNDER 21

DATE OF DEATH
1934

PLACE OF DEATH

LOCALITY OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

FINAL CAUSE

OTHER CAUSE

OTHER CAUSE

OTHER CAUSE

OTHER CAUSE

OTHER CAUSE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12270

Reg. Dist. No.

12294

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jones Creek (19)</u>		c. LENGTH OF STAY IN 1b <u>18 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jones Creek (19)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2418 Ketchum Avenue</u>				d. STREET ADDRESS <u>2418 Ketchum Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>WILTON</u> Last <u>KRAEMER, Sr.</u>				4. DATE OF DEATH Month <u>November</u> Day <u>15th</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9, 1917</u>	9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Copper & Brass</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Charles William Kraemer</u>			
14. MOTHER'S MAIDEN NAME <u>Laura Masson Kraemer</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>213-09-1410</u>				17. INFORMANT <u>Mrs. Erma M. Kraemer same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cocainy Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Baltimore</u>		(County) <u>Baltimore</u>		(State) <u>Maryland</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M B Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Melvin B. Davis, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11/17/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/19/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BelAir Memorial Gardens BelAir, Maryland</u>			
22d. LOCATION (City, town, or county) <u>Baltimore</u>		(State) <u>Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooks Bradley, Inc.</u>			
ADDRESS <u>Dundalk 22, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Registrar		12. Signature of Burial Officer	
13. Signature of Undertaker		14. Signature of Funeral Home		15. Signature of Cemetery	
16. Signature of Church		17. Signature of Minister		18. Signature of Family	
19. Signature of Friends		20. Signature of Neighbors		21. Signature of Community	
22. Signature of State		23. Signature of Nation		24. Signature of World	
25. Signature of Universe		26. Signature of Cosmos		27. Signature of Galaxy	
28. Signature of Solar System		29. Signature of Planet		30. Signature of Moon	
31. Signature of Ocean		32. Signature of Sea		33. Signature of Lake	
34. Signature of River		35. Signature of Stream		36. Signature of Brook	
37. Signature of Pond		38. Signature of Swamp		39. Signature of Marsh	
40. Signature of Field		41. Signature of Meadow		42. Signature of Pasture	
43. Signature of Forest		44. Signature of Woods		45. Signature of Grove	
46. Signature of Park		47. Signature of Garden		48. Signature of Yard	
49. Signature of Street		50. Signature of Avenue		51. Signature of Road	
52. Signature of Highway		53. Signature of Bridge		54. Signature of Tunnel	
55. Signature of Station		56. Signature of Airport		57. Signature of Port	
58. Signature of Harbor		59. Signature of Bay		60. Signature of Sound	
61. Signature of Strait		62. Signature of Gulf		63. Signature of Inlet	
64. Signature of Fjord		65. Signature of Loch		66. Signature of Lough	
67. Signature of Lake		68. Signature of Sea		69. Signature of Ocean	
70. Signature of World		71. Signature of Universe		72. Signature of Cosmos	
73. Signature of Galaxy		74. Signature of Solar System		75. Signature of Planet	
76. Signature of Moon		77. Signature of Ocean		78. Signature of Sea	
79. Signature of Lake		80. Signature of River		81. Signature of Stream	
82. Signature of Brook		83. Signature of Pond		84. Signature of Swamp	
85. Signature of Marsh		86. Signature of Field		87. Signature of Meadow	
88. Signature of Pasture		89. Signature of Forest		90. Signature of Woods	
91. Signature of Grove		92. Signature of Park		93. Signature of Garden	
94. Signature of Yard		95. Signature of Street		96. Signature of Avenue	
97. Signature of Road		98. Signature of Highway		99. Signature of Bridge	
100. Signature of Tunnel		101. Signature of Station		102. Signature of Airport	
103. Signature of Port		104. Signature of Harbor		105. Signature of Bay	
106. Signature of Sound		107. Signature of Strait		108. Signature of Gulf	
109. Signature of Inlet		110. Signature of Fjord		111. Signature of Loch	
112. Signature of Lough		113. Signature of Lake		114. Signature of Sea	
115. Signature of Ocean		116. Signature of World		117. Signature of Universe	
118. Signature of Cosmos		119. Signature of Galaxy		120. Signature of Solar System	
121. Signature of Planet		122. Signature of Moon		123. Signature of Ocean	
124. Signature of Sea		125. Signature of Lake		126. Signature of River	
127. Signature of Stream		128. Signature of Brook		129. Signature of Pond	
130. Signature of Swamp		131. Signature of Marsh		132. Signature of Field	
133. Signature of Meadow		134. Signature of Pasture		135. Signature of Forest	
136. Signature of Woods		137. Signature of Grove		138. Signature of Park	
139. Signature of Garden		140. Signature of Yard		141. Signature of Street	
142. Signature of Avenue		143. Signature of Road		144. Signature of Highway	
145. Signature of Bridge		146. Signature of Tunnel		147. Signature of Station	
148. Signature of Airport		149. Signature of Port		150. Signature of Harbor	
151. Signature of Bay		152. Signature of Sound		153. Signature of Strait	
154. Signature of Gulf		155. Signature of Inlet		156. Signature of Fjord	
157. Signature of Loch		158. Signature of Lough		159. Signature of Lake	
160. Signature of Sea		161. Signature of Ocean		162. Signature of World	
163. Signature of Universe		164. Signature of Cosmos		165. Signature of Galaxy	
166. Signature of Solar System		167. Signature of Planet		168. Signature of Moon	
169. Signature of Ocean		170. Signature of Sea		171. Signature of Lake	
172. Signature of River		173. Signature of Stream		174. Signature of Brook	
175. Signature of Pond		176. Signature of Swamp		177. Signature of Marsh	
178. Signature of Field		179. Signature of Meadow		180. Signature of Pasture	
181. Signature of Forest		182. Signature of Woods		183. Signature of Grove	
184. Signature of Park		185. Signature of Garden		186. Signature of Yard	
187. Signature of Street		188. Signature of Avenue		189. Signature of Road	
190. Signature of Highway		191. Signature of Bridge		192. Signature of Tunnel	
193. Signature of Station		194. Signature of Airport		195. Signature of Port	
196. Signature of Harbor		197. Signature of Bay		198. Signature of Sound	
199. Signature of Strait		200. Signature of Gulf		201. Signature of Inlet	
202. Signature of Fjord		203. Signature of Loch		204. Signature of Lough	
205. Signature of Lake		206. Signature of Sea		207. Signature of Ocean	
208. Signature of World		209. Signature of Universe		210. Signature of Cosmos	
211. Signature of Galaxy		212. Signature of Solar System		213. Signature of Planet	
214. Signature of Moon		215. Signature of Ocean		216. Signature of Sea	
217. Signature of Lake		218. Signature of River		219. Signature of Stream	
220. Signature of Brook		221. Signature of Pond		222. Signature of Swamp	
223. Signature of Marsh		224. Signature of Field		225. Signature of Meadow	
226. Signature of Pasture		227. Signature of Forest		228. Signature of Woods	
229. Signature of Grove		230. Signature of Park		231. Signature of Garden	
232. Signature of Yard		233. Signature of Street		234. Signature of Avenue	
235. Signature of Road		236. Signature of Highway		237. Signature of Bridge	
238. Signature of Tunnel		239. Signature of Station		240. Signature of Airport	
241. Signature of Port		242. Signature of Harbor		243. Signature of Bay	
244. Signature of Sound		245. Signature of Strait		246. Signature of Gulf	
247. Signature of Inlet		248. Signature of Fjord		249. Signature of Loch	
250. Signature of Lough		251. Signature of Lake		252. Signature of Sea	
253. Signature of Ocean		254. Signature of World		255. Signature of Universe	
256. Signature of Cosmos		257. Signature of Galaxy		258. Signature of Solar System	
259. Signature of Planet		260. Signature of Moon		261. Signature of Ocean	
262. Signature of Sea		263. Signature of Lake		264. Signature of River	
265. Signature of Stream		266. Signature of Brook		267. Signature of Pond	
268. Signature of Swamp		269. Signature of Marsh		270. Signature of Field	
271. Signature of Meadow		272. Signature of Pasture		273. Signature of Forest	
274. Signature of Woods		275. Signature of Grove		276. Signature of Park	
277. Signature of Garden		278. Signature of Yard		279. Signature of Street	
280. Signature of Avenue		281. Signature of Road		282. Signature of Highway	
283. Signature of Bridge		284. Signature of Tunnel		285. Signature of Station	
286. Signature of Airport		287. Signature of Port		288. Signature of Harbor	
289. Signature of Bay		290. Signature of Sound		291. Signature of Strait	
292. Signature of Gulf		293. Signature of Inlet		294. Signature of Fjord	
295. Signature of Loch		296. Signature of Lough		297. Signature of Lake	
298. Signature of Sea		299. Signature of Ocean		300. Signature of World	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12271

Reg. Dist. No.

12295

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 ESSEX</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>112 MARGARET AVE</u>				d. STREET ADDRESS <u>112 MARGARET AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>IRVIN E KROLL</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-28-08</u>		9. AGE (in years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARTENDER</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>OSCAR KROLL</u>				14. MOTHER'S MAIDEN NAME <u>HANNAH FREDERICK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS. BARBARA KROLL (SAME AS ABOVE)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Jack E Collins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JACK E COLLINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-25-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO.</u> <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Connolly</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles J. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

12272

12208

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1043 Maiden Choice Lane				d. STREET ADDRESS 1043 Maiden Choice Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Arthur Middle C Last LaBonte				4. DATE OF DEATH Month November Day 17 Year 1959			
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 21, 1901	
9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Crib Foreman				10b. KIND OF BUSINESS OR INDUSTRY Western Elec. Co		11. BIRTHPLACE (State or foreign country) Holyoke, Mass.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Wilbrod LaBonte				14. MOTHER'S MAIDEN NAME Marie L. (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 015-03-7100		17. INFORMANT Irene B. LaBonte, 1043 Maiden Choice Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. myocardial infarction (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 days INTERVAL BETWEEN ONSET AND DEATH 4 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov 13 , 19 59 , to Nov 17 , 19 59 , that I last saw the deceased alive on Nov 15 , 19 59 , and that death occurred at 7 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4001 Wilkes Ave DATE SIGNED 11-17-59 ACTUAL SIGNATURE Karl Pass M.D. Earl Pass PHYSICIAN'S NAME (Type) I. EARL PASS							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-20-59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street ADDRESS				24a. REC'D BY REGISTRAR NOV 19 59 DATE		24b. REGISTRAR'S SIGNATURE Arthur J. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12345

Reg. No. 12345

1. NAME OF DECEASED JOHN M. CHOLAS		2. SEX Male		3. AGE 45		4. RACE White		5. BIRTH DATE 11-23-1900		6. BIRTH PLACE Baltimore, Md.	
7. DECEASED DATE 11-23-1950		8. DECEASED TIME 10:00 AM		9. DECEASED PLACE Home		10. DECEASED CAUSE Heart Disease		11. DECEASED DOCTOR J. M. Smith		12. DECEASED HOSPITAL None	
13. DECEASED ADDRESS 1234 Main St., Baltimore, Md.		14. DECEASED CITY Baltimore		15. DECEASED STATE Md.		16. DECEASED COUNTRY U.S.A.		17. DECEASED ZIP CODE 21201		18. DECEASED COUNTY Baltimore	
19. DECEASED MARITAL STATUS Married		20. DECEASED OCCUPATION Teacher		21. DECEASED EDUCATION High School		22. DECEASED RELIGION Catholic		23. DECEASED ETHNICITY None		24. DECEASED ANCESTRY None	
25. DECEASED SOCIAL SECURITY NO. 123-45-6789		26. DECEASED MEDICAL RECORD NO. 123456789		27. DECEASED VITAL RECORD NO. 123456789		28. DECEASED DEATH CERTIFICATE NO. 123456789		29. DECEASED BURIAL RECORD NO. 123456789		30. DECEASED CREMATION RECORD NO. 123456789	

31. DECEASED SIGNATURE J. M. Smith		32. DECEASED TITLE Physician		33. DECEASED ADDRESS 1234 Main St., Baltimore, Md.		34. DECEASED CITY Baltimore		35. DECEASED STATE Md.		36. DECEASED COUNTRY U.S.A.	
37. DECEASED SIGNATURE J. M. Smith		38. DECEASED TITLE Physician		39. DECEASED ADDRESS 1234 Main St., Baltimore, Md.		40. DECEASED CITY Baltimore		41. DECEASED STATE Md.		42. DECEASED COUNTRY U.S.A.	
43. DECEASED SIGNATURE J. M. Smith		44. DECEASED TITLE Physician		45. DECEASED ADDRESS 1234 Main St., Baltimore, Md.		46. DECEASED CITY Baltimore		47. DECEASED STATE Md.		48. DECEASED COUNTRY U.S.A.	
49. DECEASED SIGNATURE J. M. Smith		50. DECEASED TITLE Physician		51. DECEASED ADDRESS 1234 Main St., Baltimore, Md.		52. DECEASED CITY Baltimore		53. DECEASED STATE Md.		54. DECEASED COUNTRY U.S.A.	
55. DECEASED SIGNATURE J. M. Smith		56. DECEASED TITLE Physician		57. DECEASED ADDRESS 1234 Main St., Baltimore, Md.		58. DECEASED CITY Baltimore		59. DECEASED STATE Md.		60. DECEASED COUNTRY U.S.A.	

12296 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: BALTIMORE COUNTY

COUNTY

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

4. DATE

(Month)

(Day)

(Year)

OF DEATH:

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at Work ☐Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1959, to Nov 1959, that I last saw the deceased

alive on Nov 22, 1959, and that death occurred at 4:15 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

NOV 24 '59

Arthur A. Thomas

N.W. JENKINS & SONS Co. 4905 YORK RD.

MARGIN RESERVED FOR BINDING

11

12297 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STEVENSON				c. LENGTH OF STAY IN 1b X STEVENSON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VILLA JULIE				d. STREET ADDRESS VILLA JULIE - VALLEY RD.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) SISTER MARIE CHAIRE (ELIZABETHE, LEAHY)				4. DATE OF DEATH Month NOV. Day 18 Year 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 12, 1874	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. EDUCATOR		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS		11. BIRTHPLACE (State or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME WILLIAM LEAHY				14. MOTHER'S MAIDEN NAME MARY HARRINGTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Sister Mary Patrick - Villa Julie			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Renal Vascular disease 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) old age. DUE TO (c) 1 year.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 , to Nov 18 , 19 59 , that I last saw the deceased alive on Nov. 14 , 19 59 , and that death occurred at 2 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Harold H. Burns M.D. 115 C. City N 11-18-59							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Harold H. Burns					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-59		22c. NAME OF CEMETERY OR CREMATORY Trinity Conv. Cemetery		22d. LOCATION (City, town, or county) (State) Ilchester, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fairley Funeral Home - Catonsville, Ind.				24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
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100. Signature of jury		101. Signature of jury		102. Signature of jury	

THE CONTENT
OF THIS
CERTIFICATE
IS
THE PROPERTY
OF THE
STATE OF
MARYLAND
AND
SHOULD
NOT
BE
REPRODUCED
OR
TRANSMITTED
IN ANY
MANNER
WITHOUT
THE
WRITTEN
CONSENT
OF THE
STATE OF
MARYLAND

1

1. Name of deceased
2. Sex
3. Age
4. Date of death
5. Time of death
6. Place of death
7. Cause of death
8. Manner of death
9. Signature of physician
10. Signature of registrar
11. Signature of informant
12. Signature of witness
13. Signature of funeral director
14. Signature of undertaker
15. Signature of cemetery
16. Signature of health officer
17. Signature of coroner
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100. Signature of jury
101. Signature of jury
102. Signature of jury

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12275

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Arbutus</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1112 Sulfur Spring Rd</u>			d. STREET ADDRESS <u>1112 Sulfur Spring Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Levi</u> Last			4. DATE OF DEATH Month <u>Nov</u> Day <u>29</u> Year <u>1959</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1882</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>	
13. FATHER'S NAME <u>? Levi</u>			14. MOTHER'S MAIDEN NAME <u>Harriet Whittington</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Mabel Brown, 1112 Sulfur Spring Rd</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Vascular disease</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>10-15 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Nov 30 59</u>	
EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-2-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Co., Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Frances A. Hemsley</u>		ADDRESS <u>573 W. Biddle St</u>		24a. REC'D BY REGISTRAR <u>DEC 1 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hems</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. TIME OF DEATH</p>		<p>10. PLACE OF DEATH</p>		<p>11. SIGNATURE OF MEDICAL EXAMINER</p>		<p>12. SIGNATURE OF WITNESS</p>	
<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF NEXT OF KIN</p>		<p>15. SIGNATURE OF CLERK</p>		<p>16. SIGNATURE OF JURY</p>	
<p>17. SIGNATURE OF JURY</p>		<p>18. SIGNATURE OF JURY</p>		<p>19. SIGNATURE OF JURY</p>		<p>20. SIGNATURE OF JURY</p>	
<p>21. SIGNATURE OF JURY</p>		<p>22. SIGNATURE OF JURY</p>		<p>23. SIGNATURE OF JURY</p>		<p>24. SIGNATURE OF JURY</p>	
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<p>29. SIGNATURE OF JURY</p>		<p>30. SIGNATURE OF JURY</p>		<p>31. SIGNATURE OF JURY</p>		<p>32. SIGNATURE OF JURY</p>	
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<p>37. SIGNATURE OF JURY</p>		<p>38. SIGNATURE OF JURY</p>		<p>39. SIGNATURE OF JURY</p>		<p>40. SIGNATURE OF JURY</p>	
<p>41. SIGNATURE OF JURY</p>		<p>42. SIGNATURE OF JURY</p>		<p>43. SIGNATURE OF JURY</p>		<p>44. SIGNATURE OF JURY</p>	
<p>45. SIGNATURE OF JURY</p>		<p>46. SIGNATURE OF JURY</p>		<p>47. SIGNATURE OF JURY</p>		<p>48. SIGNATURE OF JURY</p>	
<p>49. SIGNATURE OF JURY</p>		<p>50. SIGNATURE OF JURY</p>		<p>51. SIGNATURE OF JURY</p>		<p>52. SIGNATURE OF JURY</p>	
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<p>89. SIGNATURE OF JURY</p>		<p>90. SIGNATURE OF JURY</p>		<p>91. SIGNATURE OF JURY</p>		<p>92. SIGNATURE OF JURY</p>	
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<p>97. SIGNATURE OF JURY</p>		<p>98. SIGNATURE OF JURY</p>		<p>99. SIGNATURE OF JURY</p>		<p>100. SIGNATURE OF JURY</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12299

CERTIFICATE OF DEATH

Reg. Dist. No.

12276

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESACO PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE #6			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 501 PATAPSCO AVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LESTER E. LINTON				4. DATE OF DEATH Month NOVEMBER Day 5 Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 4, 1912	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months 4 Days 9 Hours 49 Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCCER	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCCER		10b. KIND OF BUSINESS OR INDUSTRY SELF		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARTHUR LINTON				14. MOTHER'S MAIDEN NAME AMELIA DILL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT ELIZABETH M. LINTON		Address SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERY DISEASE (c) HYPERTENSION						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9:29.55 19 11.5 19 59 , that I last saw the deceased alive on 11.5.59 19 59 , and that death occurred at 8 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John H. Orth				ADDRESS (Street, city or town, state) Rosedale Medical Group 8019 Philadelphia Rd.			
PHYSICIAN'S NAME (Type) John H. Orth				DATE SIGNED Nov 9 '59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-9-59		22c. NAME OF CEMETERY OR CREMATORY WESTERN CEM.		22d. LOCATION (City, town, or county) (State) EDMONDSON AVE. BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Labarker & Seiler				ADDRESS 901 S. CONKLING ST. BALTO., MD.		24a. REC'D BY REGISTRAR DATE NOV 9 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

CERTIFICATE OF DEATH

12399

12399

DECEASED NAME: WHITE, ROBERT SEX: MALE AGE: 65 DATE OF BIRTH: APR 1912 PLACE OF BIRTH: NEW YORK OCCUPATION: SELF MARITAL STATUS: MARRIED DATE OF DEATH: APR 1978 PLACE OF DEATH: AT HOME CAUSE OF DEATH: HEART DISEASE MANNER OF DEATH: NATURAL SIGNATURE OF DECEASED: _____ SIGNATURE OF WITNESSES: _____ SIGNATURE OF PHYSICIAN: _____ SIGNATURE OF REGISTRAR: _____ DATE OF REGISTRATION: APR 1978 PLACE OF REGISTRATION: BALTIMORE OFFICIAL USE ONLY REGISTRATION NO.: _____ INDEXING NO.: _____ FILE NO.: _____ DATE OF FILING: _____ OFFICE OF THE REGISTRAR BALTIMORE, MARYLAND	
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12300
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland 1615-2			
c. LENGTH OF STAY IN 1b 4yr3mth19dys				d. STREET ADDRESS 3509 Madison Place			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Elma Middle Basnight Last Lupton		4. DATE OF DEATH		Month 11 Day 11 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1882		9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 331X DUE TO Cerebrovascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis (c) Chronic brain syndrome assoc. with senile brain disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome assoc. with senile brain disease 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct. 9, 1959 , to Nov. 11, 1959 , that I last saw the deceased alive on Nov. 11, 1959 , and that death occurred at 2:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 11/11/59 ACTUAL SIGNATURE Bruno Radauska M.D. BRUNO RADAUS'KHS' Catonsville 28, Maryland PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11/12/59		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Wash., D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE A. H. Heines Co Washington ADDRESS				24a. REC'D BY REGISTRAR NOV 16 '59 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death		6. Place of Death		7. Cause of Death		8. Signature of Physician		9. Signature of Registrar	
JAMES EARL RAY		Male		35		April 22, 1928		April 4, 1968		St. Louis, Missouri		Suicide by gunshot		[Signature]		[Signature]	
10. Occupation		11. Marital Status		12. Education		13. Religion		14. Race		15. Birthplace		16. Usual Residence		17. Informant		18. Informant's Address	
Attorney		Single		High School		Catholic		White		St. Louis, Missouri		St. Louis, Missouri		James Earl Ray		St. Louis, Missouri	
19. Date of Burial		20. Place of Burial		21. Name of Burial Place		22. Name of Minister		23. Name of Officiant		24. Name of Witnesses		25. Name of Undertaker		26. Name of Funeral Home		27. Name of Cemetery	
April 6, 1968		St. Louis, Missouri		St. Louis, Missouri		St. Louis, Missouri		St. Louis, Missouri		St. Louis, Missouri		St. Louis, Missouri		St. Louis, Missouri		St. Louis, Missouri	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12278

12301

1. PLACE OF DEATH a. COUNTY XXXXXX Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14 Oakway Rd				e. STREET ADDRESS 14 Oakway Rd.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last BERTUS LYMBERG				4. DATE OF DEATH Month Day Year Nov. 20. 1959 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1, 1905		9. AGE (In years last birthday) 54 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		10b. KIND OF BUSINESS OR INDUSTRY Merchant Marine		11. BIRTHPLACE (State or foreign country) Holland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roelof Lymberg				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-03-0769		17. INFORMANT Address Hazel E. Lymberg-14 Oakway Rd. Timonium			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 973.3 Carbon Monoxide Poisoning Sudden. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles F. O'Donnell				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Charles F. O'Donnell				DATE SIGNED 11/20/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/24/59		22c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Gardens		22d. LOCATION (City, town, or county) (State) Timonium, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc.				ADDRESS Towson, Maryland		24a. REC'D BY REGISTRAR DATE NOV 23 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12301

NAME OF DECEASED JAMES H. HARRIS		AGE 65		SEX Male		RACE White	
DATE OF DEATH April 14, 1944		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
OCCUPATION Retired		EDUCATION High School		RELIGION Methodist		MARRIAGE Married	
PREVIOUS ILLNESS Hypertension		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		MEDICAL HISTORY Hypertension, Atherosclerosis	
SIGNS AND SYMPTOMS Chest pain, shortness of breath		TESTS AND EXAMINATIONS ECG, X-ray		TREATMENT Aspirin, Morphine		POST-MORTEM None	
FAMILY HISTORY None		SOCIAL HISTORY None		HISTORICAL DATA None		PHYSICAL DATA None	
LABORATORY DATA None		X-RAY DATA None		ECG DATA None		PATHOLOGICAL DATA None	
MICROSCOPIC DATA None		BACTERIOLOGICAL DATA None		SEROLOGICAL DATA None		HISTOCHEMICAL DATA None	
HISTOPATHOLOGICAL DATA None		CYTOLOGICAL DATA None		IMMUNOLOGICAL DATA None		GENETIC DATA None	
ANTHROPOLOGICAL DATA None		LINGUISTIC DATA None		PSYCHOLOGICAL DATA None		PSYCHIATRIC DATA None	
SOCIAL DATA None		ECONOMIC DATA None		LEGAL DATA None		MEDICAL DATA None	
OTHER DATA None		REMARKS None		SIGNATURE None		DATE None	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12302

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Md.		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Philip M. Middle Lynch Last Lynch		4. DATE OF DEATH Month November Day 19 , Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/18/1888
9. AGE (In years lost birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 71 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director		10b. KIND OF BUSINESS OR INDUSTRY Funeral Director Baltimore, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James P. Lynch		14. MOTHER'S MAIDEN NAME Mary Gaierty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-10-7682	
17. INFORMANT Mrs. Mary O'Connor Lynch - 3003 Cresmont		Address (Same)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Ca of prostate to brain DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ca of prostate DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 29, 1957 , to Nov 18, 1959 , that I last saw the deceased alive on Nov 18, 1959 , and that death occurred at 7:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 205 Medical Arts Bldg Baltimore, Md. DATE SIGNED Nov 18, 1959			
ACTUAL SIGNATURE C. Michael France M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-23-59	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co. Balto. 12, Md.		24a. REC'D BY REGISTRAR NOV 23 59	24b. REGISTRAR'S SIGNATURE Wm. S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

12302

John M. Jones, Jr.
Age 65 years
Married
Residence 1234 Main St., Baltimore, Md.
Occupation Merchant
Cause of Death Myocardial Infarction
Date of Death January 15, 1962
Place of Death Home
Physician J. M. Smith, M.D.
Hospital St. Joseph's Hospital, Baltimore, Md.
Burial or Disposition Buried in St. Joseph's Cemetery, Baltimore, Md.
Date of Burial January 17, 1962
Signature of Physician J. M. Smith
Signature of Registrar [Signature]
Signature of Coroner [Signature]

11-22-62

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12303

CERTIFICATE OF DEATH

Reg. Dist. No.

12280

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Towson</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenarm Road</u>		d. STREET ADDRESS <u>Glenarm Road</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sister Mary Adeltrudis Manz</u>		4. DATE OF DEATH Month Day Year <u>November 5 19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1874</u>
9. AGE (In years lost birthday) yrs. <u>85</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>	11. BIRTHPLACE (State or foreign country) <u>Germany</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Manz</u>	
14. MOTHER'S MAIDEN NAME <u>Walburga Strobel</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sister M. Peter Fourier</u> Address <u>Notch Cliff, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Hypertensive Cardio Renal Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>53</u> , to <u>Nov.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 23</u> , 19 <u>59</u> , and that death occurred at <u>9:40 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>7501 York Road Towson, 4, Md.</u> <u>11/6/59</u> ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D. PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-7-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>NOTCH CLIFF NR TOWSON, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Jester</u> ADDRESS <u>901 S. CONKLING ST. BALTO., 24, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12304

CERTIFICATE OF DEATH

12281

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7908 Springway Road				d. STREET ADDRESS 7908 Springway Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HENRY Middle OLIVER Last MARTEL				4. DATE OF DEATH Nov. 21, 1959 Month Nov. Day 21 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 25, 1884	9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Martel				14. MOTHER'S MAIDEN NAME Virginia Marcou			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 002-03-3659		17. INFORMANT Address Josephine H. Martel-7908 Springway Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ARTERIOSCLEROSIS DUE TO 334x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS, General DUE TO (c) 10 yrs							INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6210 York Rd	
20f. (City or town) Baltimore				20g. (County) Baltimore		20h. (State) Maryland	
21. I certify that I attended the deceased from Feb. 3, 1959 to Nov. 21, 1959 , that I last saw the deceased alive on Nov. 20, 1959 , and that death occurred at 2:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A.S. Chalfant				DATE SIGNED Nov. 21, 1959		ADDRESS (Street, city or town, state) Baltimore, Md.	
PHYSICIAN'S NAME (Type) Dr. A.S. CHALFANT				SIGNATURE Arthur S. Chalfant			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11/24/59		22c. NAME OF CEMETERY OR CREMATORY Hanover-New Hampshire		22d. LOCATION (City, town, or county) (State) Hanover-New Hampshire	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc.				24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Chalfant	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12305

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO HIGHLANDS</u>		c. LENGTH OF STAY IN 1b <u>6 MONTHS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO HIGHLANDS</u> d. STREET ADDRESS <u>3010 ALABAMA AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ADOLPH</u> First <u>MARTIN</u> Middle <u>7</u> Last		4. DATE OF DEATH <u>11-7-59</u> Month <u>11</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 8 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR: Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MOLDS MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GLASS CO</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO CITY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEDNARD MARTIN</u>		14. MOTHER'S MAIDEN NAME <u>AUGUSTATTEMME</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>34-03-2211</u>	
17. INFORMANT <u>MRS ANNAGETZ</u>		Address <u>3010 ALABAMA AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C.V.D.</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 Minutes</u> <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3.1.59</u> , 19____, to <u>11.7.59</u> , 19____, that I last saw the deceased alive on <u>11.6.59</u> , 19____, and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Nathan Racusin</u>		ADDRESS (Street, city or town, state) <u>206 S. Gilmer st.</u> DATE SIGNED <u>11.7.59</u>	
PHYSICIAN'S NAME (Type) <u>NATHAN RACUSIN</u>		<u>139 1th. 23 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-10-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WESTERN</u>		22d. LOCATION (City, town, or county) (State) <u>EDMONDSON AVE CITY 23</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo H Leimbach</u>		ADDRESS <u>525 W. LYNDA HURST ST</u>	
24a. REC'D BY REGISTRAR <u>NOV 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur P. Thomas</u>	

W 1-5-59 69

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18		12302	
CERTIFICATE OF DEATH			
1. NAME OF DECEASED <u>JOHN J. HARRIS</u>		2. SEX <u>MALE</u>	
3. AGE <u>68</u>		4. DATE OF BIRTH <u>1901</u>	
5. PLACE OF BIRTH <u>NEW YORK</u>		6. OCCUPATION <u>RETIRED</u>	
7. MARITAL STATUS <u>MARRIED</u>		8. DATE OF MARRIAGE <u>1925</u>	
9. PLACE OF DEATH <u>HOME</u>		10. CAUSE OF DEATH <u>HEART DISEASE</u>	
11. MEDICAL HISTORY <u>NO</u>		12. SURVIVAL <u>NO</u>	
13. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		14. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
15. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		16. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
17. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		18. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
19. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		20. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
21. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		22. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
23. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		24. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
25. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		26. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
27. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		28. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
29. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		30. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
31. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		32. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
33. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		34. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
35. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		36. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
37. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		38. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
39. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		40. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
41. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		42. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
43. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		44. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
45. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		46. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
47. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		48. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
49. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		50. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
51. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		52. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
53. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		54. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
55. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		56. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
57. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		58. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
59. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		60. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
61. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		62. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
63. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		64. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
65. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		66. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
67. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		68. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
69. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		70. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
71. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		72. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
73. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		74. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
75. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		76. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
77. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		78. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
79. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		80. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
81. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		82. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
83. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		84. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
85. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		86. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
87. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		88. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
89. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		90. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
91. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		92. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
93. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		94. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
95. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		96. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
97. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		98. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	
99. SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u>		100. SIGNATURE OF WITNESS <u>JOHN J. HARRIS</u>	

12306

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 7, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Kenneth Donald McAllister</u>		4. DATE OF DEATH Month Day Year <u>November 14, 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 31, 1914</u>
9. AGE (In years last birthday) yrs. <u>44</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>44</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Westinghouse</u>	
11. BIRTHPLACE (State or foreign country) <u>Seattle, Wash.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Claire McAllister</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>531-05-9592</u>	
17. INFORMANT <u>Mrs. Helen M. McAllister</u>		Address <u>Baltimore 7, Md</u> <u>3800 Arbutus Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary artery occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arteriosclerotic Artery Disease</u> (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive cerebrovascular disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Spring</u> , 19 <u>56</u> , to <u>Nov 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 14</u> , 19 <u>59</u> , and that death occurred at <u>7P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ronni Dahman</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>713 Milford Mill Rd Pikesville</u> <u>9/14/59</u>	
PHYSICIAN'S NAME (Type) <u>Louis DALMAN M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>Nov. 18, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 18 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12100

12100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12284

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12199

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>46 TOWNSHIP ROAD</u>		d. STREET ADDRESS <u>46 TOWNSHIP ROAD</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>MCCAFFREY</u> Last <u>MCCAFFREY</u>	4. DATE OF DEATH Month <u>NOV.</u> Day <u>12</u> Year <u>1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 16, 1909</u>
9. AGE (in years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PENN.</u>	11. BIRTHPLACE (State or foreign country) <u>PENN.</u>
12. CITIZEN OF WHAT COUNTRY			
13. FATHER'S NAME <u>EDWARD</u>		14. MOTHER'S MAIDEN NAME <u>MARY FITZMAURICE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MARY MCCAFFREY, 46 TOWNSHIP Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A-S-C-V Disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>11/12/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>NOV. 14/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lilly & Zeiler Inc., 403 S. Wolfe St.</u>		24a. REC'D BY REGISTRAR <u>NOV 16 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur & Hanna</u>

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

12108

1. Name of Deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of Birth: Jan 15, 1900

5. Place of Birth: New York City

6. Usual Residence: 123 Main St, Baltimore, Md.

7. Date of Death: Dec 10, 1945

8. Time of Death: 10:30 AM

9. Place of Death: Home

10. Cause of Death: Myocardial Infarction

11. Manner of Death: Natural

12. Signature of Medical Examiner: [Signature]

13. Date of Certificate: Dec 15, 1945

14. Registrar's Signature: [Signature]

15. Date of Registration: Dec 15, 1945

12307

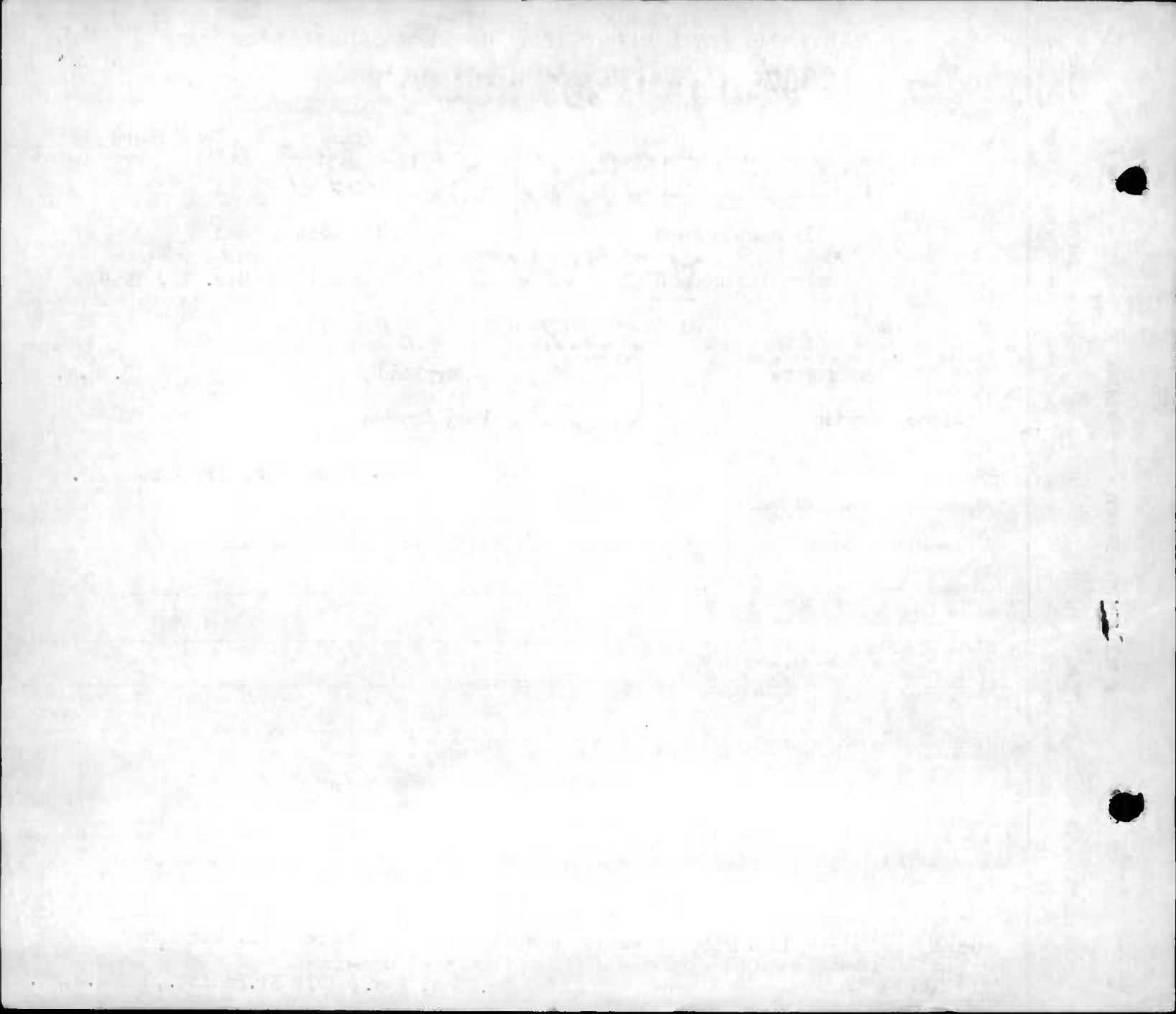
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Essex</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>339 Worton Road</u>				STREET ADDRESS (If rural give location) <u>339 Worton Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Daisy Ida McCann</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>Nov. 12, 1959</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>8/26/1885</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Sidney Dryden</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Dryden</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Mary McC. Messenger, 339 Worton Rd.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.1 CORONARY OCCLUSION</u>						<u>1 DAY</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>ARTERIO-SCLEROTIC CARDIO-VASC. DISEASE</u>						<u>10 YRS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 12, 1959</u> , to <u>Nov. 12, 1959</u> , that I last saw the deceased alive on <u>Nov. 12, 1959</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Louis Semeno</u>		ADDRESS <u>M. D. 2108 CREMS RD, Baltimore 20, Md.</u>		DATE SIGNED <u>11/12/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/14/59</u>		NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		LOCATION (City, town, or county) (State) <u>Rock Hall, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>NOV 16 '59</u>		REGISTRAR'S SIGNATURE <u>William S. Kraus</u>		24. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook, Inc., 1217 St. Paul St., Balt o. 2, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12308

CERTIFICATE OF DEATH

12286

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson-4-Md.		c. LENGTH OF STAY IN 1b 3 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last McHugh		4. DATE OF DEATH Month 11 Day 6 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/24/1873
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 8 Days 6 Hours 11 Min. 59	IF UNDER 24 HRS. Months 8 Days 6 Hours 11 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christopher Donegan		14. MOTHER'S MAIDEN NAME Mary Fitzgerald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO 16-yr (c) 16-yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 19 56 to November 19 59 , that I last saw the deceased alive on November 4 19 59 , and that death occurred at 5:44 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		ADDRESS (Street, city or town, state) 7501 York Rd Baltimore, Md.	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell- M.D.		DATE SIGNED 4/6/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11-9-59	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck ADDRESS 5305 Harford Rd		24a. REC'D BY REGISTRAR NOV 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

12308

Name of Deceased		John Doe	
Sex		Male	
Age		45	
Date of Birth		Jan 15, 1900	
Place of Birth		Baltimore, Md.	
Usual Residence		123 Main St, Baltimore, Md.	
Cause of Death		Heart Disease	
Date of Death		Dec 10, 1945	
Place of Death		Home	
Physician		Dr. J. K. Smith	
Burial Place		Greenwood Cemetery	
Burial Date		Dec 15, 1945	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Official Seal		[Seal]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12309

CERTIFICATE OF DEATH

12287

Reg. Dist. No.

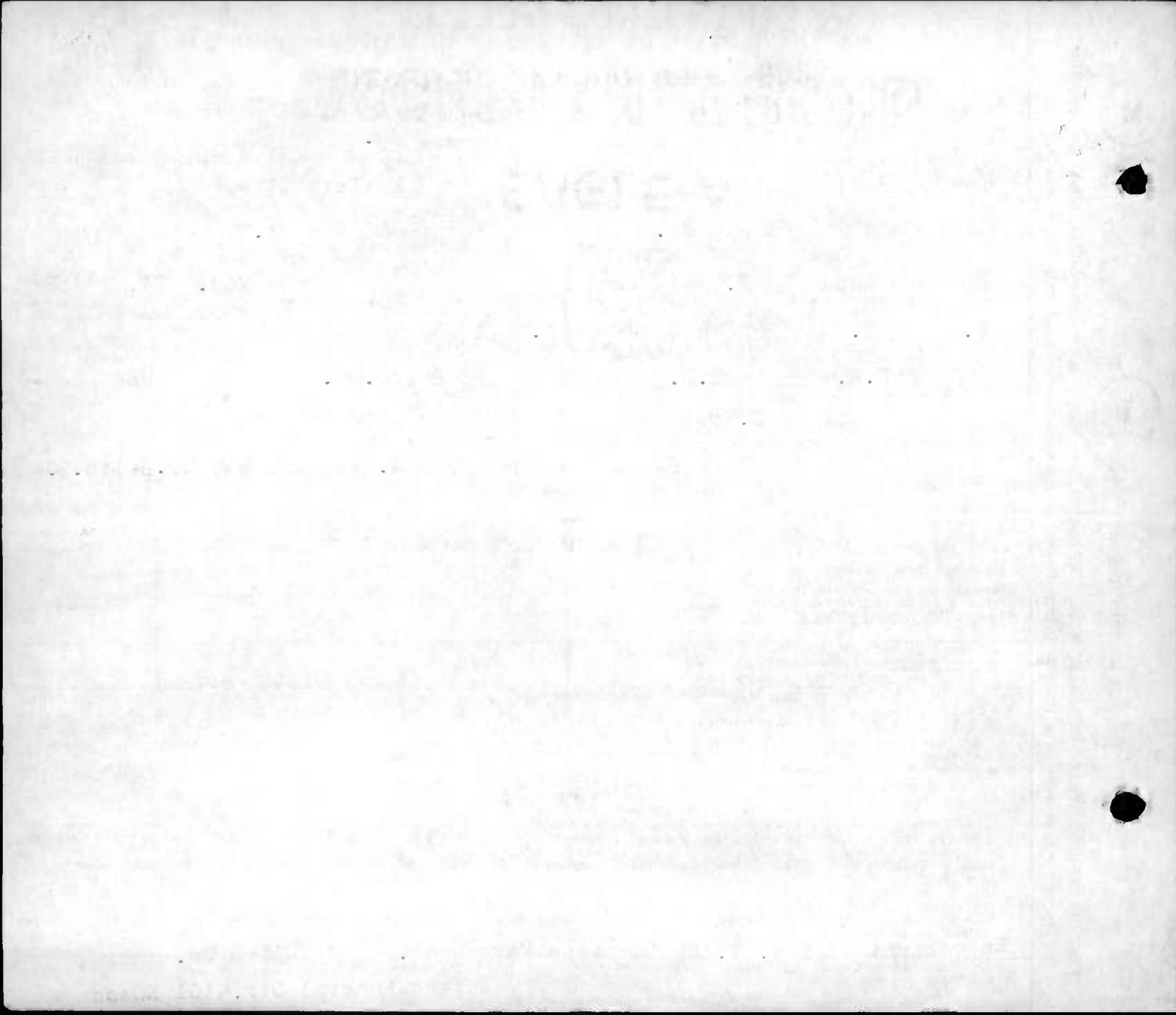
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Baltimore	STATE	Md. COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Bowleys Qtrs	CITY (If outside corporate limits, write RURAL OR and give nearest town)	Bowleys Qtrs
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	255 Bay Dr.	STREET ADDRESS (If rural give location)	255 Bay Dr.

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First)	(Middle)	(Last)	
Edna	F.	Meil	
5. SEX:		6. COLOR OR RACE:	
F.	W.		
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
Married		Aug. 10, 1893	
9. AGE last birthday		66 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	
H.W.		O.H.	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Balto. Md.		USA	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Joseph C. Fowler		Charlotte Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		219-03-2901	
17. INFORMANT & ADDRESS:		William A. Meil, 255 Bay Dr. Balto. 20	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE		
(A) Carcinoma of Gall Bladder, metastatic		5 mo.
ANTECEDENT CAUSE (S)		
(B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION
Sept 1959		Carcinoma of gall bladder
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>
		21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1955, to Nov. 24, 1959, that I last saw the deceased alive on Nov. 24, 1959, and that death occurred at 8 A M, from the causes and on the date stated above.			
SIGNATURE		ADDRESS	DATE SIGNED
Louis Semenovoff		M. D. 2108 Conn Rd. Balto. 20 Md	11/24/59
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Entombment	Nov. 27, '59	Lorraine Park Cemt.	Woodlawn Md.
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
NOV 27 '59		Witzke Funeral Dir. 4101 Edmon	1501 N. E. 1st St. S.W.



12200

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3018 Dunleer Road		d. STREET ADDRESS 3018 Dunleer Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OSCAR Middle EARL Last MEREDITH		4. DATE OF DEATH Month November Day 17 , Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1894
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James E. Meredith		14. MOTHER'S MAIDEN NAME ? Meredith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. Mrs. Madeline Meredith 3018 Dunleer Road.	
17. INFORMANT Mrs. Madeline Meredith 3018 Dunleer Road.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A-S-C-U Disease + Pulmonary DUE TO Emphysema (c) Emphysema		INTERVAL BETWEEN ONSET AND DEATH 5 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April - 1954 , to Nov. 17, 1959 , that I last saw the deceased alive on Nov. 6, 1959 , and that death occurred at 10:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6800 MORNINGTON ROAD DATE SIGNED 11/20/59			
ACTUAL SIGNATURE M.B. Davis		M.D. DUNDALK - MD	
PHYSICIAN'S NAME (Type) M-B. Davis M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/23/59	22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge	22d. LOCATION (City, town, or county) (State) Dorsey, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.		24a. REC'D BY REGISTRAR DATE NOV 27 '59	
		24b. REGISTRAR'S SIGNATURE Charles S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12310

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood 1634.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 4103 - 41st Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Mario Last Messina		4. DATE OF DEATH Month November Day 10 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1885
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Cutter		10b. KIND OF BUSINESS OR INDUSTRY Marble	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Salvatore Messina		14. MOTHER'S MAIDEN NAME Rose	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 102-09-4456	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral vascular accident DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Senility	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 28 , 19 59 , to Nov. 10 , 19 59 , that I last saw the deceased alive on Nov. 10 , 19 59 , and that death occurred at 10:20a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 11-10-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/13/59	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Nalley Funeral Home Mt. Rainier		24a. REC'D BY REGISTRAR DATE NOV 16 '59	
ADDRESS Dorc.		24b. REGISTRAR'S SIGNATURE Arthur S. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12310

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10/15/1910"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md"]		OCCUPATION [Faint text, possibly "Teacher"]	
MARITAL STATUS [Faint text, possibly "Married"]		DATE OF MARRIAGE [Faint text, possibly "05/10/1935"]	
PLACE OF DEATH [Faint text, possibly "Home"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
TIME OF DEATH [Faint text, possibly "10:15 AM"]		DATE OF DEATH [Faint text, possibly "08/10/1955"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
CITY [Faint text, possibly "Baltimore"]		COUNTY [Faint text, possibly "Baltimore"]	
STATE [Faint text, possibly "Md"]		ZIP CODE [Faint text, possibly "21201"]	

THIS CERTIFICATE IS VALID FOR THE PURPOSE OF OBTAINING A PASSPORT ONLY. IT DOES NOT CONSTITUTE A LEGAL DOCUMENT. FOR LEGAL PURPOSES, A DEATH CERTIFICATE MUST BE OBTAINED FROM THE STATE DEPARTMENT OF HEALTH.

12311

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 87 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2310 Mayfield Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First KAROL Middle -- Last MIECZKOWSKI				4. DATE OF DEATH Month November Day 22 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 25, 1894	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min.		IF UNDER 24 HRS. Months 65 Days 65 Hours 65 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sausage Maker				10b. KIND OF BUSINESS OR INDUSTRY Meat Company		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Anthony Mieczkowski				14. MOTHER'S MAIDEN NAME Rosalie (Maiden Name Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I				16. SOCIAL SECURITY NO. 217-07-9958			
INFORMANT Address Clin. Records, VAH, Balto. Md., Ft. Howard Div.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) UNKNOWN INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year VA 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 27, 1959 to November 22, 1959 , and that death occurred at 2:10A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE George C. McElpatrick M.D. VAH, BALTO. MD. - FT HOWARD DIVISION 11/22/59							
PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M.D. VAH, BALTO. MD. - FT HOWARD DIVISION 11/22/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/59		22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS WM. FIALKOWSKI FUNERAL HOME, 2007 Eastern Ave. Balto 24, Md.				24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kram	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

First Name

Last Name

Place of Birth

Age

Sex

Occupation

Date

Time

Place of Death

Cause of Death

Signature of Physician

Signature of Registrar

Date

Place of Death

CERTIFICATE OF DEATH

Reg. Dist. No. 12291

12312

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 11 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD C. MIELKE First Middle Last Served as: EDWIN C. MIELKE		4. DATE OF DEATH Month NOVEMBER Day 27 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 19, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY Painting	9. AGE (In years lost birthday) 72 yrs.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AUGUST MIELKE		14. MOTHER'S MAIDEN NAME BERTHA CHALK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. unk.	
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE STOMACH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) METASTATIC ADENOCARCINOMA TO PERIGASTRIC, PERI-PANCREATIC, PERIAORTIC LYMPH NODES, LIVER, LUNGS (c) & ADRENALS ---- JAUNDICE			INTERVAL BETWEEN ONSET AND DEATH Unknown 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 16, 1959 to November 27, 1959 , that I was the attending physician and that death occurred at 3:36 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH Balto., Md., Ft. Howard Div. 11/28/59			
ACTUAL SIGNATURE Harold R. Johnson M.D.		PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-30-59	
22c. NAME OF CEMETERY OR CREMATORY CREAGERSTOWN CEMETERY		22d. LOCATION (City, town, or county) (State) CREAGERSTOWN, FREDERICK CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WEER & HAIGHT, Sykesville, Maryland		24a. REC'D BY REGISTRAR DATE DEC 1 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

13313

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BOSTON

1901

NO

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FOR STATE HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12292

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sunnybrook		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sunnybrook	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) RACHEL		4. DATE OF DEATH Month November Day 3 Year 19 59	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/3/59			
ACTUAL SIGNATURE William V. Lovitt, Jr.		EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.	
22a. BURNING, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11.30.59	
22c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School		22d. LOCATION (City, town, or country) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	
VS. A15ME 5M 7/59		DATE DEC 1 '59	

100

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1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-Rodgers Forge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 44 Dunkirk Road		d. STREET ADDRESS 44 Dunkirk Road	
3. NAME OF DECEASED (Type or print) First RICHARD Middle ARTHUR Last MOORE		4. DATE OF DEATH Nov. 19, 1959 Day 19 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1905
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min. 54	IF UNDER 24 HRS. Months 54 Days 54 Hours 54 Min. 54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer		10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martz Arnold Moore		14. MOTHER'S MAIDEN NAME Fannie Carlton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Vera G. Moore-44 Dunkirk Rd-Balto.12	
17. INFORMANT Vera G. Moore-44 Dunkirk Rd-Balto.12		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Brain DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of Lung metastasis DUE TO Lung (c) Lung		INTERVAL BETWEEN ONSET AND DEATH 14 da 30 da	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 10, 1959 to Nov 14, 1959 , that I last saw the deceased alive on Nov 19, 1959 , and that death occurred at 1:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1138 North Parkway 212 DATE SIGNED Nov 20, 1959			
ACTUAL SIGNATURE Wm Cook M.D.		DATE SIGNED Nov 20, 1959	
PHYSICIAN'S NAME (Type) 1138 North Parkway 212			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 23, 1959	22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. Towson, Md.		24a. REC'D BY REGISTRAR DATE NOV 23 59	
		24b. REGISTRAR'S SIGNATURE William S. Moore	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

12315

Item 1 Film G252 12-17-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12294

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison, Md.</u> c. LENGTH OF STAY IN 1b <u>2 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3002 Churchentery, Tenn</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Victoria</u> First Middle Last <u>None</u>				4. DATE OF DEATH <u>Nov</u> Month <u>3</u> Day <u>19</u> Year <u>59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 6, 1900</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper Cook</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>303-12-9499</u>		17. INFORMANT <u>George Foster</u> Address <u>2097 E. Edgewood St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>433.1</u> DUE TO <u>Cerebral embolus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>chronic Myocarditis int</u> (c) <u>auricular fibrillation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u> <u>one year</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Oct 30</u> , 19 <u>59</u> , to <u>Nov 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 30</u> , 19 <u>59</u> , and that death occurred at <u>7</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Palmer F. Williams</u> M.D.				ADDRESS (Street, city or town, state) <u>1725 Reisterstown Rd. Pikesville 8, Md.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>PALMER F. WILLIAMS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/6/59</u>		<u>Mt Auburn</u>		<u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl Gilmore</u> ADDRESS <u>519 Mosher St</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12316

CERTIFICATE OF DEATH

12295

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>102 S. SYMINGTON AVE</u>		d. STREET ADDRESS <u>1102 S. SYMINGTON AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HARVEY</u> Middle <u>J.</u> Last <u>MORRISER</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 13, 1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRAFTSMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B.O.R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Morriser</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fitzpatrick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W.I.</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Harvey J. Morriser - 107 Symington Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric intestinal hemorrhage</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of pancreas with liver metastasis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>6 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 26, 1959</u> to <u>Nov. 29, 1959</u> , that I last saw the deceased alive on <u>Nov. 29, 1959</u> , and that death occurred at <u>10:05 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John N. Snyder</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>6348 FREDERICK RD</u> <u>12/1/59</u>	
PHYSICIAN'S NAME (Type) <u>JOHN N. SNYDER, M.D.</u>		<u>BALTIMORE 28, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-2-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fairfax Funeral Home - Catonsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 3 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12317

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12296

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
				Baltimore		3401-4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mt. Vista & Belair Roads				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
RAYMOND F. BROZINSKI				November 15 19 59			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4/10/37		22 yrs.	Months Days	Hours Min.
1Da. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		1Db. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer		Food Mach. Corp		Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No				Family - Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide intoxication and smoke inhalation 823x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Conflagration DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
2Da. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Auto wreck with resulting conflagration					
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. 5 11/15 19 59		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		2Df. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
<i>W. Bradley King, Jr.</i>		W. Bradley King, Jr., M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/15/59	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
B		11/19/59		Parkwood		Baltimore	
23. FUNERAL DIRECTOR				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
McCully Funeral Homes - 130 E. Fort Ave.				NOV 17 '59		<i>Arline L. Hines</i>	

1581

2. DATE OF DEATH 11/13/59

17. INFORMANT	ADDRESS
Mrs. Paul J. Flynn	3700 Greenmount

4 weeks

5 years

422.1 ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO Diabetes Mellitus

2 years

11

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONITION CAUSING IT.

IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☐ ND ☐

22. I certify that (I) (~~this hospital~~) attended the deceased from July 15 1994 to Nov 21 1999, that (I) (~~we~~) last saw the deceased alive on Nov 21 1999, and that death occurred at 5 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23c. DATE SIGNED

ATTENDING PHYS. ☐

MEQ. DIRECTOR ☐

STAFF PHYS. ☐

11 E. Chase St

11/6/58

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

LOCAL REGISTRAR
NDV 16 1959

(4th Grade)

2. Transfer
WINTERBORN

PLEASE TYPE, WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. THIS IS A PERMANENT RECORD.

Every item of informative carefully supplied. Physicians: please write the causes of death clearly and in full. This is a permanent record.

THIS CERTIFICATE MUST BE FILED WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER THE DATE OF DEATH.

TO HOSPITAL OR

CERTIFICATE OF DEATH

1931

DECEASED'S NAME (Print Name and Surname) _____		SEX _____ AGE _____	
PLACE OF BIRTH _____ DATE OF BIRTH _____		PLACE OF DEATH _____ DATE OF DEATH _____	
OCCUPATION _____ CAUSE OF DEATH _____		MEDICAL ATTENDANCE _____ SIGNATURE OF MEDICAL ATTENDANT _____	
SIGNATURE OF DECEASED'S NEAREST RELATIVE _____ NAME OF NEAREST RELATIVE _____		SIGNATURE OF REGISTRAR _____ NAME OF REGISTRAR _____	

This certificate is valid only if it is signed by the Medical Attendant and the Registrar. It is not valid if it is signed by any other person.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12319

CERTIFICATE OF DEATH

12298

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 6 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1508 N. Rutland Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CHARLES Middle ADAM Last MUTH, JR.		4. DATE OF DEATH Month November Day 4 Year 1959					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1911	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Tavern		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles A. Muth, Sr.				14. MOTHER'S MAIDEN NAME Mary Burnham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 212-10-6423		INFORMANT Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE BLEEDING GASTRIC ULCER 540.0 XEROX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE ANEMIA XEROX (c) CIRRHOSIS OF LIVER PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1.. Esophageal Varices. 2. Edema of lungs.						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN 9 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 29, 1959 to November 4, 1959 and that death occurred at 9:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Crawford		ADDRESS (Street, city or town, state) M.D. VAH, BALTO. 18, MD. FORT HOWARD DIVISION					
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		DATE SIGNED 11/5/59 11/5/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-9-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard Hück		ADDRESS 5305 Harford Road Baltimore, Maryland		24a. REC'D BY REGISTRAR DATE NOV 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

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12320

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks c. LENGTH OF STAY IN 1b Sparks d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springtown Rd.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks d. STREET ADDRESS Springtown Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edwin Middle H. Nicholson Last Nicholson		4. DATE OF DEATH Month Nov. Day 18 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1886
9. AGE (In years last birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) real estate	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jacob K. Nicholson	
14. MOTHER'S MAIDEN NAME Fannie Ogher		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. INFORMANT Olive Nicholson Address same		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypercalcemia DUE TO (c) coronary insufficiency	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO		INTERVAL BETWEEN ONSET AND DEATH 1 yr. 1 yr. 4 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-59 to 11-18-59 , that I last saw the deceased alive on 11-17-59 , and that death occurred at 1:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Peisterstown, Md. DATE SIGNED 11-19-59 ACTUAL SIGNATURE James G. Saffell PHYSICIAN'S NAME (Type) James G. Saffell			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11-21-59	
22c. NAME OF CEMETERY OR CREMATORY Parkwood cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck ADDRESS 5305 Harford Rd		24. REC'D BY REGISTRAR NOV 23 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12321

CERTIFICATE OF DEATH

12300

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balta</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>	
c. LENGTH OF STAY IN 1b <u>25yrs.</u>		d. STREET ADDRESS <u>Rayville Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>Rayville Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert P. Noel</u>		4. DATE OF DEATH <u>Nov. 30, 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Febr. 9, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pvt. Dept. Laborer Service Station</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Noel</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>512-033987</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malnutrition, Autism</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition, Autism</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>9:30 p. m. 11, 30 1959</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/29</u> , 19 <u>59</u> , to <u>11-30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/30</u> , 19 <u>59</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Herbert Mueller</u> M.D.		ADDRESS (Street, city or town, state) <u>Parkton P.O. Md</u> DATE SIGNED <u>12/1/59</u>	
PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER</u>		<u>PARKTON P.O. MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Middletown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Freeland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u> ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>DEC 4 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

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1982

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

1982

REG. DIVISION

1. NAME OF DEATH		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. DATE OF DEATH		7. PLACE OF BIRTH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DEATH CERTIFICATE	
JAMES EARL RAY		M		39		W		12-1-42		12-8-68		MEMPHIS, TENN.		MEMPHIS, TENN.		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH		16. NAME OF HOSPITAL		17. NAME OF PHYSICIAN		18. NAME OF NURSE		19. NAME OF CHAPLAIN		20. NAME OF MINISTER		21. NAME OF OTHER		22. NAME OF OTHER		23. NAME OF OTHER		24. NAME OF OTHER	
12-8-68		12:00 PM		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH		16. NAME OF HOSPITAL		17. NAME OF PHYSICIAN		18. NAME OF NURSE		19. NAME OF CHAPLAIN		20. NAME OF MINISTER		21. NAME OF OTHER		22. NAME OF OTHER		23. NAME OF OTHER		24. NAME OF OTHER	
12-8-68		12:00 PM		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12323

CERTIFICATE OF DEATH

12302

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY V	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c. LENGTH OF STAY IN 1b 8mth13dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 834 Brooks Lane	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Arthur Middle Harry Last Palmer		4. DATE OF DEATH Month November Day 3 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1892
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR Months 6 Days 7 Hours 15 Min.	11. IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Salesman		10b. KIND OF BUSINESS OR INDUSTRY Mutual of Omaha	11. BIRTHPLACE (State or foreign country) Tennessee
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME (Unknown) Palmer	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 215-22-3567		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infarctive myocardial fibrosis DUE TO (c) Hypertensive and arteriosclerotic cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) SPRING GROVE STATE HOSPITAL		(County) (State)	
21. I certify that I attended the deceased from Feb. 27, 19 59 , to Nov. 3, 19 59 , that I last saw the deceased alive on Nov. 3, 19 59 , and that death occurred at 7:15a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		DATE SIGNED 11-3-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		ADDRESS (Street, city or town, state) Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-6-59	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Woodlawn, Md
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE NOV 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12324

CERTIFICATE OF DEATH

Reg. Dist. No. 12303

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON				c. LENGTH OF STAY IN 1b 9 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 646 CHARLES STREET AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CLIFTON TODD PERKINS				4. DATE OF DEATH Month Day Year NOVEMBER 10, 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 20, 1901	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN - COMM. MENTAL HYGIENE				10b. KIND OF BUSINESS OR INDUSTRY AUBURN MAINE		11. BIRTHPLACE (State or foreign country) U. S. A.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME DR. EVERETT C. PERKINS				14. MOTHER'S MAIDEN NAME LOUISE M. TODD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. INFORMANT Address MRS ANNIE MARGARET PERKINS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix 1530 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-9 , 19 59 , to 11-10 , 19 59 , that I last saw the deceased alive on 11-9 , 19 59 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 29 Alleghany Ave, Towson DATE SIGNED 11-11-59 ACTUAL SIGNATURE Robert E. Ensor M.D. PHYSICIAN'S NAME (Type) ROBERT E. ENSOR, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/12/ 59		22c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY		22d. LOCATION (City, town, or county) (State) AMESBURY MASSACHUSETTS	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTIMORE MD.				24a. REC'D BY REGISTRAR DATE NOV 13 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1338

CENTRAL AVE OF LEATH

1338

BALTIMORE

MARYLAND

BALTIMORE

TOWSON

9 YRS

1900

600 CHASE STREET, BALTIMORE, MD

600 CHASE STREET, BALTIMORE, MD

NOVEMBER 19, 1900

CLINTON TOWN, BALTIMORE

WATSON, J. W.

WATSON, J. W.

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WATSON, J. W.

WATSON, J. W.

SALARY STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12325

CERTIFICATE OF DEATH

12304

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Pro Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7 Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md. 1615-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Augsburg Lutheran Home		d. STREET ADDRESS Kennedy St	
3. NAME OF DECEASED (Type or print) First Katherine Middle PETERS Last NOV		4. DATE OF DEATH Month NOV Day 18 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1895
9. AGE (In years lost birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired clerk Post Office Department		10b. KIND OF BUSINESS OR INDUSTRY France	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Peters		14. MOTHER'S MAIDEN NAME Barbara Schini	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
INFORMANT Anna Kramer		Address Glen ndale Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) - Cerebral Hemorrhage (Rt. side) 7 days DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) (2) Hypertensive Heart Disease 5 yrs. DUE TO (c) Obesity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1959 to Nov. 18, 1959 , that I last saw the deceased alive on Nov. 18-59 , 19 59 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl L. Chambers		ADDRESS (Street, city or town, state) 4108 Liberty Hts Baltimore Md. 11-18-59	
PHYSICIAN'S NAME (Type) Earl L. Chambers		DATE SIGNED 4108-Liberty Hts Baltimore Md -	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov 21, 1959	22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	22d. LOCATION (City, town, or county) (State) Bowie, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Maryland.	
24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

1952

6571090 5211

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12326

CERTIFICATE OF DEATH

Reg. Dist. No.

12305

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6635 Ritchie Highway 0250-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>		d. STREET ADDRESS <u>Brooklyn, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Annie Eleanor</u> Middle <u>Phelps</u> Last <u></u>		4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1959</u>	
S. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11, 1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Franklin Manshaw</u>		14. MOTHER'S MAIDEN NAME <u>Annie Eliza Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Cerebral arterio-sclerosis</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>59</u> , to <u>present</u> , 19 <u></u> , that I last saw the deceased alive on <u>10/30/59</u> , 19 <u>59</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest C. Brown Jr.</u>		ADDRESS (Street, city or town, state) <u>1101 N. Calvert St. Balt.</u>	
PHYSICIAN'S NAME (Type) <u>Ernest C. Brown, Jr.</u>		DATE SIGNED <u>11/2/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/6/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell & Sons, Inc. 1900 Eutaw Place</u>		24a. REC'D BY REGISTRAR <u>NOV 6 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krand</u>			

1938

DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1938

Blank form with faint horizontal lines and vertical columns, typical of a vital record document. The form is oriented vertically and contains several sections for data entry, though the text is illegible due to fading. The form is divided into columns by vertical lines, and horizontal lines separate the different sections. The overall layout is typical of a standard form used for recording vital statistics.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12306

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 3yr4mth7dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS Route #10 - Box 37 - Willis ^{MILLERS}, Is.			
3. NAME OF DECEASED (Type or print) First Josephine Middle Pitelli Last Pitelli				4. DATE OF DEATH Month November Day 9 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 19, 1909		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS		10b. KIND OF BUSINESS OR INDUSTRY CLOTHING		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vincent Pitelli				14. MOTHER'S MAIDEN NAME Catherine AKERZA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records; SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 923.7 DUE TO Foreign material in trachea and bronchus (aspirated food) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) accident DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Foreign material in trachea and bronchus					
20c. TIME OF INJURY Month, Day, Year 9-35-59 Hour a. m. p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville Baltimore Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George M. Kieffer				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 12/59		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) 4430 Belair Rd.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank Della Noce				ADDRESS 322 S. High St.		24a. REC'D BY REGISTRAR DATE NOV 12 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Hays			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12307

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. LENGTH OF STAY IN 1b <u>52</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>21 Melrose Ave.</u>				d. STREET ADDRESS <u>21 Melrose Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gabriel</u> Middle <u>Pollock</u> Last				4. DATE OF DEATH Month <u>Nov.</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1 1906</u>		9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Pollock</u>				14. MOTHER'S MAIDEN NAME <u>Annie Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>2-17-610734</u>		17. INFORMANT Name <u>John W. Pollock</u> Address <u>1032 N. Gilmore St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a. m. p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-17-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Western Star Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Catonsville, Balto., Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Thomas A. Henry</u>				ADDRESS <u>578 W. Biddle St.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 17 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur G. Kenna</u>

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12308

Reg. Dist. No.

Items 8 & 9, Film G-252 11/24/59.cac.

12201

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b ?	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2727 Old North Point Road		e. STREET ADDRESS 106 German Hill Road	
3. NAME OF DECEASED (Type or print) First Thomas Middle Patrick Last Porter		4. DATE OF DEATH Month November Day 6 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1896 Sept. 28, 1891
9. AGE (in years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer on Penna. R R Co.	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 205-05-2431		17. INFORMANT Mrs. Esther Tabaka Address 106 German Hill Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) ASCVD Disease (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M. B. DAVIS M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 10, 59	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) St. Clair, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda		ADDRESS 7922 Wise Ave. 22, Maryland	
24a. REC'D BY REGISTRAR NOV 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1888

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF INTERVIEWER

NAME OF INTERVIEWER

NAME OF INTERVIEWER

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12309

12209

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1711 Selma Ave.		d. STREET ADDRESS 1711 Selma Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emma J. Middle Pullen Last		4. DATE OF DEATH Nov. 18/59 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1870
9. AGE (In years lost birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ---Hickmann		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Mildred Parsons, 1711 Selma Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myo cardial insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio-sclerotic cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 18 19 59 to Nov 18 19 59 that I lost saw the deceased alive on Nov 18 19 59 , and that death occurred at 4:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4116 Edmondson Avenue DATE SIGNED			
ACTUAL SIGNATURE George A. Knipp		M.D. 4116 Edmondson Avenue	
PHYSICIAN'S NAME (Type) George A. Knipp, M.D.		Baltimore, 29, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 21/59	22c. NAME OF CEMETERY OR CREMATORY St. Paul's	
22d. LOCATION (City, town, or county) (State) Violetville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE NOV 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

CERTIFICATE OF DEATH

12200

BALTIMORE

BALTIMORE

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BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12329

CERTIFICATE OF DEATH

Reg. Dist. No.

12310

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARBOR VIEW		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X HARBOR VIEW	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 630 S. 47TH ST. #24		d. STREET ADDRESS 630 S. 47TH ST. #24	
3. NAME OF DECEASED (Type or print) First HENRY Middle RASSELE Last SR.		4. DATE OF DEATH Month NOV. Day 10 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 9, 1888.
9. AGE (In years lost birthday) yrs. 71		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY SELF	
11. BIRTHPLACE (State or foreign country) AUSTRIA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOSEPH RASSELE		14. MOTHER'S MAIDEN NAME MOSER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-18-0629	
17. INFORMANT LENA RASSELE		Address SAME.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 13 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 21, 1958 to Nov. 11, 1959 , that I last saw the deceased alive on Nov. 11, 1959 , and that death occurred on Nov. 11, 1959 at 8:42 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Eugene F. Nevey		ADDRESS (Street, city or town, state) 7201 Mornington Rd Dundalk Md	
PHYSICIAN'S NAME (Type) Eugene F Nevey M.D.		DATE SIGNED 11-12-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-13-59	
22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.		22d. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Geiler		ADDRESS 901 S. CONKLING ST. BALTO. 24, MD.	
24a. REC'D BY REGISTRAR NOV 13 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Krawitz	

12330

CERTIFICATE OF DEATH

12311

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V0/-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPI-TAL</u>				d. STREET ADDRESS <u>1808 St. Paul Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>William</u> Last <u>Redford</u>				4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20, 1912</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>(Unknown)</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Raymond Redford, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Catherine Chapman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>220-14-4093</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic coronary thrombosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>2 months</u> <u>undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Sept. 11, 1959</u> , to <u>Nov. 27, 1959</u> , that I last saw the deceased alive on <u>Nov. 27, 1959</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D.			ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u>		DATE SIGNED <u>11/27/59</u>		
PHYSICIAN'S NAME (Type) <u>BRUNO RADAUSKAS</u>			Catonsville 28, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal, Burial- Nov. 30, 1959</u>	22b. DATE THEREOF <u>Nov. 30, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beverlyview</u>	22d. LOCATION (City, town, or county) <u>Richmond, Virginia</u>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Bailey Co. Richmond, Va.</u>			24a. REC'D BY REGISTRAR DATE <u>DEC 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kras</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10330

Reg. Dist. No.

1. NAME OF DECEASED JAMES H. BROWN		2. SEX Male		3. AGE 45		4. PLACE OF BIRTH New York	
5. DATE OF DEATH Nov 10 1911		6. TIME OF DEATH 10:30 AM		7. PLACE OF DEATH Home		8. CAUSE OF DEATH Heart Disease	
9. DISEASE OR INJURY Heart Disease		10. PRESENT ILLNESS Heart Disease		11. PREVIOUS ILLNESS None		12. OCCASION OF DEATH Sudden	
13. NAME OF PHYSICIAN Dr. J. H. Smith		14. NAME OF NURSE Mrs. J. H. Smith		15. NAME OF FUNERAL HOME None		16. NAME OF BURIAL PLACE None	
17. SIGNATURE OF PHYSICIAN J. H. Smith		18. SIGNATURE OF NURSE Mrs. J. H. Smith		19. SIGNATURE OF FUNERAL HOME None		20. SIGNATURE OF BURIAL PLACE None	
21. SIGNATURE OF DECEASED None		22. SIGNATURE OF NEXT OF KIN None		23. SIGNATURE OF WITNESSES None		24. SIGNATURE OF REGISTRAR None	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12331

CERTIFICATE OF DEATH

Reg. Dist. No.

12312

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 25 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 105 N. Ellwood Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN W. REIMER Served As: JOHN W. REIMERS				4. DATE OF DEATH Month November Day 25 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/2/97	
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours		11. IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard				10b. KIND OF BUSINESS OR INDUSTRY Venetian Blind Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Reimer				14. MOTHER'S MAIDEN NAME Anna Lohn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I				16. SOCIAL SECURITY NO. 216-03-7077			
INFORMANT Clin. Rec. VAH, Balto 18, Md. Ft. Howard Division				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DIABETES MELLITUS 260X Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) MARKED GENERALIZED ARTERIOSCLEROSIS DUE TO (c) UNKNOWN INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 24, 1959 to November 25, 1959 and that death occurred at 1:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur T. Faulk, M.D.				ADDRESS (Street, city or town, state) VAH, BALTO. 18, MD. FT. HOWARD DIVISION			
PHYSICIAN'S NAME (Type) ARTHUR T. FAULK, M.D.				DATE SIGNED 11/26/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-30-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.				ADDRESS 6009 Harford Road Baltimore 14, Maryland		24a. REC'D BY REGISTRAR DEC 2 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Age

Sex

Married

Occupation

Place of Birth

Religion

Signature

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12313

12332

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 10 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 616 South 48th Street, Baltimore d. STREET ADDRESS 616 South Forty-eighth Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle A. Last REITZ				4. DATE OF DEATH Month November Day 24 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 7, 1892	
9. AGE (In years last birthday) yrs. 67		10. UNDER 1 YEAR Months 6		11. UNDER 24 HRS. Days 10		12. UNDER 24 HRS. Hours 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector (Car)				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME George Reitz				14. MOTHER'S MAIDEN NAME Carrie Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 717-07-7313			
17. INFORMANT Clin. Rec., VAH, Balto. 18, Md., Fort Howard Div.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA 422.1 DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6. CARCINOMATOSIS, GENERALIZED							
INTERVAL BETWEEN ONSET AND DEATH 1 DAY 10 DAYS							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from November 14, 1959 , to November 24, 1959 , and that death occurred at 8:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO. 18, MD. FT. HOWARD DIV. DATE SIGNED 11/24/59							
ACTUAL SIGNATURE John W. Crawford				M.D. VAH, BALTO. 18, MD. FT. HOWARD DIV.			
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.				VAH, BALTO. 18, MD. FT. HOWARD DIVISION			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11/23/59			
22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery				22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE George A. Weber				24a. REC'D BY REGISTRAR NOV 25 '59			
ADDRESS George A. Weber Funeral Home, 705 S. Ann St. Balto. Md.				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

For the purpose of this certificate, the deceased is considered to have died at the place where the death occurred.

The deceased was born on the _____ day of _____, 19____, at _____, _____, _____.

He was the _____ child of _____ and _____, both of whom were living at the time of his birth.

He was educated at _____, _____, _____, and _____, _____, _____.

He was employed by _____, _____, _____, and _____, _____, _____.

He was married to _____, _____, _____, and _____, _____, _____.

He was a member of _____, _____, _____, and _____, _____, _____.

He was a resident of _____, _____, _____, and _____, _____, _____.

He was a citizen of _____, _____, _____, and _____, _____, _____.

He was a member of _____, _____, _____, and _____, _____, _____.

He was a member of _____, _____, _____, and _____, _____, _____.

He was a member of _____, _____, _____, and _____, _____, _____.

He was a member of _____, _____, _____, and _____, _____, _____.

He was a member of _____, _____, _____, and _____, _____, _____.

He was a member of _____, _____, _____, and _____, _____, _____.

He was a member of _____, _____, _____, and _____, _____, _____.

He was a member of _____, _____, _____, and _____, _____, _____.

He was a member of _____, _____, _____, and _____, _____, _____.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12333

12314

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Packton Rural</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NORMAN</u> Middle <u>JOSEPH</u> Last <u>RILL</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 21-1908</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Saboner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harmon</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph L Rill</u>		14. MOTHER'S MAIDEN NAME <u>Minnie B Davidson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) <u>yes world war #2</u>		16. SOCIAL SECURITY NO. <u>215-08-3591</u>	
17. INFORMANT <u>Joe L Rill</u>		Address <u>Packton Ind</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma</u> <u>581.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Cirrhosis of Liver (Laennec)</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October</u> 19 <u>58</u> , to <u>November 15</u> , 19 <u>59</u> that I last saw the deceased alive on <u>November 14</u> 19 <u>59</u> , and that death occurred at <u>7:30 A</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Md</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield, M.D.</u>		DATE SIGNED <u>11/16/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Nov 18/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Calverton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin & Gipton</u>		24a. REC'D BY REGISTRAR <u>Nov 17 '59</u>	
ADDRESS <u>Hampstead Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur & Kiana</u>	

8362

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

12315

12334

Reg. Dist. No. 22

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore County</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Pr. George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mt. Wilson, Md.</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Suitland 16X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS <u>2315 Wingate Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Lucille</u> (Middle) <u>Carrola</u> (Last) <u>Robinson</u>				(Month) <u>11</u> (Day) <u>10</u> (Year) <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>10-23-1922</u>	9. AGE last birthday <u>37</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Betty Carron</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>248-50-3935</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
1343 IMMEDIATE CAUSE (A) <u>Septicemia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Candida albicans (moniliasis)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pulmonary abscess</u>							
19a. DATE OF OPERATION <u>11/14/59</u>		19b. MAJOR FINDINGS OF OPERATION <u>Lung abscess</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/11/59</u> , to <u>11/10/59</u> , that I last saw the deceased alive on <u>10/10/59</u> , and that death occurred at <u>9:03 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wm. Newcomer</u>				ADDRESS (Street, city, town, state) <u>Superintendent, Mt. Wilson, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>Nov 13-59</u>		NAME OF CEMETERY OR CREMATORY <u>W of M cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>NOV 17 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Fann B H Newell</u>		ADDRESS	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12316

12335

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>51X-3</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville Balto 7 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DALLAS CITY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2929 Mann Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Myrtle Rose</u> First Middle Last		4. DATE OF DEATH <u>Nov. 25</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 15 1882</u> 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dry Goods Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Illinois</u>	
11. BIRTH PLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Remain. Wood</u>		14. MOTHER'S MAIDEN NAME <u>Emma Tull</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>347-24-9910</u>	
17. INFORMANT <u>Daughter 2929 Mann Ave Balto.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial degeneration</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Marked cachexia</u> DUE TO (c) <u>Carcinomatosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos. Mar 1959</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cc Breast - Radical mast left 1953</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>59</u> , to <u>Nov</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>59</u> , and that death occurred at <u>8:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9005 Harford Rd. Balto 14 Md</u> DATE SIGNED <u>11/25/59</u>			
ACTUAL SIGNATURE <u>Frank T. Kasik</u> M.D.		DATE SIGNED <u>11/25/59</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-27-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>DALLAS CITY</u>	22d. LOCATION (City, town, or county) (State) <u>DALLAS CITY ILLINOIS</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS. F. EVANS & SON 8802 HARFORD RD.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>NOV 27 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krasik</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	
JAMES EARL RAY		M		35		5-1-38		MEMPHIS, TENN.		DRIVER		MARRIED		HEART DISEASE		MEMPHIS, TENN.		5-4-68		J. EARL RAY		J. EARL RAY	
13. PLACE OF INTERMENT		14. NAME OF INTERMENT		15. DATE OF INTERMENT		16. NAME OF MINISTER		17. NAME OF CHURCH		18. NAME OF FUNERAL HOME		19. NAME OF CEMETERY		20. NAME OF BURIAL		21. NAME OF CREMATION		22. NAME OF URN		23. NAME OF CASK		24. NAME OF COFFIN	
MEMPHIS, TENN.		ST. LOUIS		5-4-68		J. EARL RAY		ST. LOUIS		J. EARL RAY		ST. LOUIS		ST. LOUIS		ST. LOUIS		ST. LOUIS		ST. LOUIS		ST. LOUIS	

TO JAMES EARL RAY
MAY 4 1968
MEMPHIS, TENN.
J. EARL RAY

12336

CERTIFICATE OF DEATH

Reg. Dist. No.

12317

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u>		b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8104 Hillendale Rd.</u>				d. STREET ADDRESS <u>8104 Hillendale Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louise G. (Lula) Roettger</u>		4. DATE OF DEATH Month Day Year <u>Nov. 10 1959</u>		5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>6-25-1904</u>		9. AGE (In years lost birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Goodrich</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>217-20-6667</u>		16. SOCIAL SECURITY NO. <u>Alroy L. Roettger</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>3 hrs</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive CVD.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>March 1959</u> to <u>Nov 10 1959</u> , that I last saw the deceased alive on <u>Nov 10 1959</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Joseph F. hi Pira</u>		M.D. <u>84 voluch Raven Blvd.</u>		ADDRESS (Street, city or town, state) <u>Balto 4, Md</u>		DATE SIGNED <u>11/11/59</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH F. hi PIRA M.D.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11-13-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	
22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		22e. DATE OF DEATH <u>Nov 10 1959</u>		22f. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		22g. REGISTRAR'S NAME <u>Leonard J. Ruck</u>	
22h. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Hartford Rd</u>		22i. REC'D BY REGISTRAR <u>NOV 13 '59</u>		22j. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

1933

1933

John Alexander
John Alexander
John Alexander

John Alexander

John Alexander

John Alexander

John Alexander

John Alexander

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John Alexander

John Alexander

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12337

CERTIFICATE OF DEATH

Reg. Dist. No.

12318

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AERO ACRES.</u>		c. LENGTH OF STAY IN 1b <u>X ROSEDALE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>IVY HALL.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ROHE</u> Last <u>ROHE</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 12, 1860</u>
9. AGE (In years last birthday) <u>99</u> yrs.		10. IF UNDER 1 YEAR Months <u>99</u> Days <u>99</u> Hours <u>99</u> Min. <u>99</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM. MILLER</u>		14. MOTHER'S MAIDEN NAME <u>MATHILDA UNKNOWN.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>PETER ROHE</u>		Address <u>KINGSVILLE MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Oct. 27, 1959</u> to <u>Oct. 27, 1959</u> that I last saw the deceased alive on <u>Oct. 27, 1959</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>Samuel Stern, M.D.</u>			
PHYSICIAN'S NAME (Type) <u>Samuel Stern, M.D.</u> <u>Ridge Road, Baltimore 6, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC 1, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		22d. LOCATION (City, town, or county) (State) <u>PARKVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sassah Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 4 '59</u>	
ADDRESS <u>7401 Belair Road</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton L. House</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12338

CERTIFICATE OF DEATH

Reg. Dist. No. 12319

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Ba <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b X Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Nursing Home-301 W. Chesapeake Ave.		d. STREET ADDRESS 3008 Dubois Ave. #14	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MAMIE Middle M. Last ROLAND		4. DATE OF DEATH Month Nov. Day 11, Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1876
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 83 Days 11 Hours 19 Min. 59	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Wesley Spicer		14. MOTHER'S MAIDEN NAME Mary E. Kroh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Verne Vandusen - 3008 Deboise Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Decompensative Cardio Vascular Disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (c) INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 25 , 19 59 , to Nov 11 , 19 59 , that I last saw the deceased alive on Nov. 11 , 19 59 , and that death occurred at 5:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6805 York Rd. Baltimore DATE SIGNED 12 Md			
ACTUAL SIGNATURE Laurence C. Post		M.D. Baltimore	
PHYSICIAN'S NAME (Type) LAURENCE C. Post			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/14/59	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. F. Dickner & Sons - Balto. 17, Md		ADDRESS	
24a. REC'D BY REGISTRAR DATE NOV 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12338

DATE OF DEATH

TIME

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

CAUSE OF DEATH

DATE

TIME

PLACE OF DEATH

DATE

TIME

PLACE OF DEATH

DATE

TIME

PLACE OF DEATH

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TIME

PLACE OF DEATH

DATE

TIME

PLACE OF DEATH

12339

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Professional House</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>-</u> Last <u>ROSENTHAL</u>		4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>69</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>
13. FATHER'S NAME <u>Abraham Cronenberg</u>		14. MOTHER'S MAIDEN NAME <u>Debrah</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Samuel Rosenthal - Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>162.1</u> DUE TO <u>CARDIO-RESPIRATORY FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PRIMARY ADENOCARCINOMA OF LUNG</u> DUE TO <u>with milium metastasis to both lungs</u> (c) <u>lung</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MARCH 2, 1956</u> to <u>NOV 2, 1959</u> , that I last saw the deceased alive on <u>NOV 2, 1959</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard E. Spengler</u> M.D.		ADDRESS (Street, city or town, state) <u>5901 Park Heights Dr Baltimore Md</u> DATE SIGNED <u>11/5/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11-4-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Kewer Inc</u> ADDRESS <u>2100 Eutaw Place</u>		24a. REC'D BY REGISTRAR <u>NOV 4 '59</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

12332

RECEIVED
JAN 10 1964
FBI - NEW YORK

RECEIVED
JAN 10 1964
FBI - NEW YORK

12340

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Reisterstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Reisterstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James G. Ross</u>		4. DATE OF DEATH Month Day Year <u>November 30, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12, 1886</u>
9. AGE (In years last birthday) yrs. <u>73</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone mason</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John B. Ross</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Byrns</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>212616-4021</u>	
17. INFORMANT <u>Mrs. Margaret R. Crouse</u>		Address <u>Owings Mills, Md.</u> wn, Rd <u>10624 Reisterstown</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>15 mins.</u> <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>51</u> to <u>November 30, 1959</u> that I last saw the deceased alive on <u>Nov. 21</u> , 19 <u>59</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>48 Main Street</u> <u>12-1-59</u>			
ACTUAL SIGNATURE <u>Martin E. Strobel</u>		M.D. <u>Reisterstown, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Martin E. Strobel M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 2, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		ADDRESS <u>Pikesville 8, Md.</u>	24a. REC'D BY REGISTRAR <u>DEC 3 '59</u>
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13340

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

12341

CERTIFICATE OF DEATH

Reg. Dist. No.

12322

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore - rural</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 12, Md. 5670 The Alameda</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Armacott Nursing Home</i>				d. STREET ADDRESS <i>812 Register Ave. 3V01-4</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Minna E. Ross</i>				4. DATE OF DEATH Month Day Year <i>November 13 1959</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>February 18, 1871</i>	9. AGE (In years last birthday) yrs. <i>88</i>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <i>Baltimore Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Alexander Mathison</i>				14. MOTHER'S MAIDEN NAME <i>Mary Robinson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Mrs Mary D. Montague</i>		Address	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of Brain</i> <i>174x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of Uterus</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i> <i>5 yrs.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 1948</i> , to <i>Nov 13, 1959</i> , that I last saw the deceased alive on <i>Nov 13, 1959</i> , and that death occurred at <i>6:45</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i> M.D.				ADDRESS (Street, city or town, state) <i>7501 York Rd.</i>		DATE SIGNED <i>11/15/59</i>	
PHYSICIAN'S NAME (Type) <i>Charles F. O'Donnell</i>				<i>Person #4 MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>11/16/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Greenmount Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran</i>				ADDRESS <i>3000 E. Baltimore St.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 17 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Criss & Kline</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1951

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>NOV 15 1951</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>HOME</i>	
7. CAUSE OF DEATH <i>HEART DISEASE</i>		8. MANNER OF DEATH <i>NATURAL</i>		9. MEDICAL HISTORY <i>None</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		11. SIGNATURE OF DECEASED <i>None</i>		12. SIGNATURE OF WITNESS <i>None</i>	
13. SIGNATURE OF REGISTRAR <i>None</i>		14. SIGNATURE OF CLERK <i>None</i>		15. SIGNATURE OF JURY <i>None</i>	
16. SIGNATURE OF JURY <i>None</i>		17. SIGNATURE OF JURY <i>None</i>		18. SIGNATURE OF JURY <i>None</i>	
19. SIGNATURE OF JURY <i>None</i>		20. SIGNATURE OF JURY <i>None</i>		21. SIGNATURE OF JURY <i>None</i>	
22. SIGNATURE OF JURY <i>None</i>		23. SIGNATURE OF JURY <i>None</i>		24. SIGNATURE OF JURY <i>None</i>	
25. SIGNATURE OF JURY <i>None</i>		26. SIGNATURE OF JURY <i>None</i>		27. SIGNATURE OF JURY <i>None</i>	
28. SIGNATURE OF JURY <i>None</i>		29. SIGNATURE OF JURY <i>None</i>		30. SIGNATURE OF JURY <i>None</i>	
31. SIGNATURE OF JURY <i>None</i>		32. SIGNATURE OF JURY <i>None</i>		33. SIGNATURE OF JURY <i>None</i>	
34. SIGNATURE OF JURY <i>None</i>		35. SIGNATURE OF JURY <i>None</i>		36. SIGNATURE OF JURY <i>None</i>	
37. SIGNATURE OF JURY <i>None</i>		38. SIGNATURE OF JURY <i>None</i>		39. SIGNATURE OF JURY <i>None</i>	
40. SIGNATURE OF JURY <i>None</i>		41. SIGNATURE OF JURY <i>None</i>		42. SIGNATURE OF JURY <i>None</i>	
43. SIGNATURE OF JURY <i>None</i>		44. SIGNATURE OF JURY <i>None</i>		45. SIGNATURE OF JURY <i>None</i>	
46. SIGNATURE OF JURY <i>None</i>		47. SIGNATURE OF JURY <i>None</i>		48. SIGNATURE OF JURY <i>None</i>	
49. SIGNATURE OF JURY <i>None</i>		50. SIGNATURE OF JURY <i>None</i>		51. SIGNATURE OF JURY <i>None</i>	
52. SIGNATURE OF JURY <i>None</i>		53. SIGNATURE OF JURY <i>None</i>		54. SIGNATURE OF JURY <i>None</i>	
55. SIGNATURE OF JURY <i>None</i>		56. SIGNATURE OF JURY <i>None</i>		57. SIGNATURE OF JURY <i>None</i>	
58. SIGNATURE OF JURY <i>None</i>		59. SIGNATURE OF JURY <i>None</i>		60. SIGNATURE OF JURY <i>None</i>	
61. SIGNATURE OF JURY <i>None</i>		62. SIGNATURE OF JURY <i>None</i>		63. SIGNATURE OF JURY <i>None</i>	
64. SIGNATURE OF JURY <i>None</i>		65. SIGNATURE OF JURY <i>None</i>		66. SIGNATURE OF JURY <i>None</i>	
67. SIGNATURE OF JURY <i>None</i>		68. SIGNATURE OF JURY <i>None</i>		69. SIGNATURE OF JURY <i>None</i>	
70. SIGNATURE OF JURY <i>None</i>		71. SIGNATURE OF JURY <i>None</i>		72. SIGNATURE OF JURY <i>None</i>	
73. SIGNATURE OF JURY <i>None</i>		74. SIGNATURE OF JURY <i>None</i>		75. SIGNATURE OF JURY <i>None</i>	
76. SIGNATURE OF JURY <i>None</i>		77. SIGNATURE OF JURY <i>None</i>		78. SIGNATURE OF JURY <i>None</i>	
79. SIGNATURE OF JURY <i>None</i>		80. SIGNATURE OF JURY <i>None</i>		81. SIGNATURE OF JURY <i>None</i>	
82. SIGNATURE OF JURY <i>None</i>		83. SIGNATURE OF JURY <i>None</i>		84. SIGNATURE OF JURY <i>None</i>	
85. SIGNATURE OF JURY <i>None</i>		86. SIGNATURE OF JURY <i>None</i>		87. SIGNATURE OF JURY <i>None</i>	
88. SIGNATURE OF JURY <i>None</i>		89. SIGNATURE OF JURY <i>None</i>		90. SIGNATURE OF JURY <i>None</i>	
91. SIGNATURE OF JURY <i>None</i>		92. SIGNATURE OF JURY <i>None</i>		93. SIGNATURE OF JURY <i>None</i>	
94. SIGNATURE OF JURY <i>None</i>		95. SIGNATURE OF JURY <i>None</i>		96. SIGNATURE OF JURY <i>None</i>	
97. SIGNATURE OF JURY <i>None</i>		98. SIGNATURE OF JURY <i>None</i>		99. SIGNATURE OF JURY <i>None</i>	
100. SIGNATURE OF JURY <i>None</i>		101. SIGNATURE OF JURY <i>None</i>		102. SIGNATURE OF JURY <i>None</i>	

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12323

Reg. Dist. No.

12342

1. PLACE OF DEATH a. COUNTY BALTIMORE Co. MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALT.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point (19)			c. LENGTH OF STAY IN 1b 53 Dundalk (22)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Inf.			d. STREET ADDRESS 3014 LIBERTY PARKWAY		
3. NAME OF DECEASED (Type or print) First CHARLES Middle FRANCIS Last RYAN, SR			4. DATE OF DEATH Month 11 Day 8 Year 1959		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 13, 1900		9. AGE (In years last birthday) 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman-Blast Furnace Steel		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Johnstown, Penna.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Micheal Ryan			14. MOTHER'S MAIDEN NAME Mary Russell		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-07-0047		17. INFORMANT Mrs. Mary K. Ryan Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH _____
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/8/59	
EXAMINER'S NAME (Type) M. B. DAVIS MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/11/59		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial	
22d. LOCATION (City, town, or county) (State) Dorsey, Maryland		24a. REC'D BY REGISTRAR NOV 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hays	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley		ADDRESS Dundalk 22			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12343

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco		c. LENGTH OF STAY IN 1b 7 Mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS Emory Rd.	
3. NAME OF DECEASED (Type or print) First Milton E. Middle Ryan Last		4. DATE OF DEATH Month November Day 8 Year 19 59	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1896
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman		10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel M. Ryan		14. MOTHER'S MAIDEN NAME Margaret Bond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212-05-7399	
17. INFORMANT Hilda M. Ryan		Address Emory Rd. Upperco, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mitral Insufficiency DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 27, 19 48 to Nov 8, 19 59 , that I last saw the deceased alive on November 6, 19 59 , and that death occurred at 10:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		ADDRESS (Street, city or town, state) 7501 York Rd. Towson #4 Maryland	
DATE SIGNED 11/10/59			
PHYSICIAN'S NAME (Type) Charles F. O'Donnell			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/11-59	
22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge		22d. LOCATION (City, town, or county) (State) Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank R. Seely		ADDRESS 814 W 36 St Balto "md"	
24a. REC'D BY REGISTRAR NOV 12 '59		24b. REGISTRAR'S SIGNATURE Charles S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12325

12344 Items 1.7 Film G251 11-16-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium c. LENGTH OF STAY IN 1b Timonium d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4 Washington Street (At work)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1914 N. Asquith St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle St. Last ROSE		4. DATE OF DEATH Month November Day 2 Year 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-19-1912
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 4 Days 17	11. IF UNDER 24 HRS. Hours 17 Min. 47
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adolph St. Rose		14. MOTHER'S MAIDEN NAME Willie Ann St. Rose	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 1914 N. Asquith St.	
17. INFORMANT Lillian St. Rose		Address 1914 N. Asquith St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-7-59	
22c. NAME OF CEMETERY OR CREMATORY My Auburn Cem Balto		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rayner Sanders		ADDRESS 217 E. Preston St.	
24a. REC'D BY REGISTRAR NOV 9 '59		24b. REGISTRAR'S SIGNATURE W. Lovitt	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12345

CERTIFICATE OF DEATH

12326

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>3 MONTHS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE 114 THE PINES</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nora L Schlatterbeck</u>		4. DATE OF DEATH Month Day Year <u>11 21 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCTOBER 31, 1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>HAGERSTOWN, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN PHILLIP SCHUELER</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH DOERNBERGER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>WILLIAM T. SCHLATTERBECK, JR.</u>		Address <u>ELLICOTT CITY, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Ischemia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u>15 yr.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-15-1959</u> , to <u>11-21-1959</u> , that I last saw the deceased alive on <u>11-20-1959</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William K. Gallagher</u>		DATE SIGNED <u>11/21/59</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		ADDRESS (Street, city or town, state) <u>Baltimore-28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/24/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Rieger</u>		ADDRESS <u>HAGERSTOWN, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

12347

CERTIFICATE OF DEATH

12328

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7108 Campfield Rd				d. STREET ADDRESS 7108 Campfield Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RUTH		First Middle Last SCHOENIJOHN		4. DATE OF DEATH Month Nov. Day 29 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1905		9. AGE (In years lost birthday) 54 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Medical		11. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Louis H. Schoenijohn				14. MOTHER'S MAIDEN NAME Emeline Abellman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-03-2902		INFORMANT Mr. Roy W. Kinstler - 7108 Campfield Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Vaginal Hemorrhage DUE TO (b) Carcinoma of the Cervix Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						INTERVAL BETWEEN ONSET AND DEATH 6 months	
21. I certify that I attended the deceased from Nov 12 , 19 59 to Nov 30 , 19 59 , that I last saw the deceased alive on Nov 24 , 19 59 , and that death occurred at 5 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Thomas S. Bowyer M.D. 221 Med Arts Bldg ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Thomas S. Bowyer						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/2/59		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balto 17				24a. REC'D BY REGISTRAR DATE DEC 1 '59		24b. REGISTRAR'S SIGNATURE William L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Conscience of the People

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12327

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Geroed Ave.				/d. STREET ADDRESS Geroed Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thelma Middle E Last Shoemaker				4. DATE OF DEATH Month Nov. Day 16 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1899		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore City		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles K. Demmitt				14. MOTHER'S MAIDEN NAME Elizabeth Smallwood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-18-9502		17. INFORMANT Elmer Shoemaker, Reisterstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 10 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour o. m. none p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		11-17-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 19/59		22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery		22d. LOCATION (City, town, or county) (State) Owings Mills, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.				24a. REC'D BY REGISTRAR NOV 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12348

CERTIFICATE OF DEATH

12329

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodmoor, Balto. 7, Md.		c. LENGTH OF STAY IN 1b 19 Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) × Randallstown,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Robb's Nursing Home				d. STREET ADDRESS 3603 Stoney Brook Road		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) George E. Simpson		First Middle Last		4. DATE OF DEATH 11 22 19 59		Month Day Year	
5. SEX M		6. COLOR OR RACE W		7. DATE OF DEATH WIDOWED		8. DATE OF BIRTH 7/3/76	
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Credit Dept.				10b. KIND OF BUSINESS OR INDUSTRY Loan & Finance		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert Simpson				14. MOTHER'S MAIDEN NAME *Blanche Nancy Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-03-2236		17. INFORMANT Mr. Robert W. Simpson			
				Address Randallstown, Md 3603 Stoney Brook Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Acute Congestive Heart Failure DUE TO (b) Pulmonary edema & renal failure DUE TO (c) Chr. Cong. Heart Failure & Hypertension INTERVAL BETWEEN ONSET AND DEATH 10 days 10-12 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 1 19 59 to NOV. 22 19 59 , that I last saw the deceased alive on NOV. 22 19 59 , and that death occurred at 6:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3601 Clifmar Road DATE SIGNED 11/22/59							
ACTUAL SIGNATURE Thomas E. Wheeler		M.D. 3601 Clifmar Road, Balto. 7, Md.					
PHYSICIAN'S NAME (Type) Thomas E. Wheeler M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/24/59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Long Myers				ADDRESS 8728 Liberty Road		24a. REC'D BY REGISTRAR NOV 25 59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Travis	
Randallstown, Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 11 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle H. Last SIRENS				4. DATE OF DEATH Month NOVEMBER Day 13 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8/12/91	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Michael J. Sirens				14. MOTHER'S MAIDEN NAME Mary Donovan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. 212-12-5264			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF RIGHT LUNG 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 3 1/2 Years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from November 2, 1959 to November 13, 1959 and that death occurred at 6:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED DAH, BALTO, 18, M.D. FORT HOWARD DIV. ACTUAL SIGNATURE David A. Oursler PHYSICIAN'S NAME (Type) DAVID A. OURSLER, M.D. DAH, BALTO, 18, MD, FORT HOWARD DIVISION 11/14/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov. 17 1959			
22c. NAME OF CEMETERY OR CREMATORY Baltimore National				22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Frank Della Noce				24a. REC'D BY REGISTRAR NOV 16 59			
24b. REGISTRAR'S SIGNATURE							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>1yr3mth5dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Sisk</u> Last <u>Sisk</u>				4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 10, 1885</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Samuel Gore</u>				14. MOTHER'S MAIDEN NAME <u>Stella Crawford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-24-2623</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized peritonitis</u> <u>570.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Volvulus of sigmoid colon</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile brain disease.</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I attended the deceased from <u>Aug. 14</u> , 19 <u>58</u> , to <u>Nov. 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 20</u> , 19 <u>59</u> , and that death occurred at <u>1:00 p. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL</u> <u>11-20-59</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u>				ADDRESS <u>4905 York Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 23 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>William L. House</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1935

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

FILE NO. 100

1. NAME OF DECEASED JOHN J. SMITH		2. SEX Male		3. AGE 45		4. DATE OF BIRTH Jan 15, 1890		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. DATE OF MARRIAGE Jan 1, 1915		9. PLACE OF MARRIAGE St. Mary's Church, Baltimore, Md.		10. NAME OF SPOUSE Mary E. Smith	
11. CAUSE OF DEATH Heart Disease		12. PLACE OF DEATH Home		13. DATE OF DEATH Jan 10, 1935		14. TIME OF DEATH 10:30 AM		15. SIGNATURE OF PHYSICIAN J. H. Jones	
16. SIGNATURE OF REGISTRAR A. B. Smith		17. SIGNATURE OF WITNESS C. D. Jones		18. SIGNATURE OF DECEASED John J. Smith		19. SIGNATURE OF SPOUSE Mary E. Smith		20. SIGNATURE OF CHILDREN None	

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE PHYSICIAN TO SIGN IT AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE CAUSE OF DEATH. IT IS THE DUTY OF THE WITNESSES TO SIGN IT AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE PLACE AND TIME OF DEATH. IT IS THE DUTY OF THE DECEASED TO SIGN IT AND TO FURNISH A TRUE AND CORRECT STATEMENT OF HIS NAME AND OCCUPATION. IT IS THE DUTY OF THE SPOUSE TO SIGN IT AND TO FURNISH A TRUE AND CORRECT STATEMENT OF HER NAME AND DATE OF MARRIAGE. IT IS THE DUTY OF THE CHILDREN TO SIGN IT AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THEIR NAMES AND DATES OF BIRTH.

12351

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1603 Providence Rd.</u>				d. STREET ADDRESS <u>1 1603 Providence Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>B.</u> Last <u>Sisson</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-2-1907</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>52</u> Days <u>52</u> Hours <u>52</u> Min. <u>52</u>		IF UNDER 24 HRS.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William E. Grueninger</u>				14. MOTHER'S MAIDEN NAME <u>Carolina Lovis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO. <u>Louis J. Sisson</u>		17. INFORMANT Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction, complete</u> 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma ovary, recurrent, metastatic, intraabdominal</u> DUE TO (c) <u>8 mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 10, 1959</u> , to <u>Aug. 26, 1959</u> , that I last saw the deceased alive on <u>Aug. 26, 1959</u> , and that death occurred at <u>8:52 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Mitchell H. Miller</u>				ADDRESS (Street, city or town, state) <u>600 W. Belvedere Avenue #10</u>			
PHYSICIAN'S NAME (Type) <u>Mitchell H. Miller, M. D.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11-12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Rd</u>		24a. REGISTERAR DATE <u>NOV 12 1959</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur G. Huns</u>							

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 ESSEX	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 316 MARGARET AVE		d. STREET ADDRESS 316 MARGARET AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN SLEPPY		4. DATE OF DEATH Month Day Year NOV 8 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 7-1910
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN		10b. KIND OF BUSINESS OR INDUSTRY EASTERN S. STEEL	
11. BIRTHPLACE (State or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME KENNETH D. SLEPPY		14. MOTHER'S MAIDEN NAME NELLIE COLLINS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-18-6054	
INFORMANT Address HALEN SLEPPY-316 MARGARET AVE			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Coronary thrombosis (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 21	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 11/8 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 8, 1959 to 11/8, 1959 , that I last saw the deceased alive on 11/8, 1959 , and that death occurred at 2 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Platt M.D.		ADDRESS (Street, city or town, state) 434 Eastern Ave. BALTO. Co. MD.	
PHYSICIAN'S NAME (Type) J. PLATT M.D.		DATE SIGNED 11/9/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV-11-1959	
22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.		22d. LOCATION (City, town, or county) (State) BALTO. Co. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John S. Connolly		ADDRESS 418 Eastern Ave East Md	
24a. REC'D BY REGISTRAR NOV 12 59		24b. REGISTRAR'S SIGNATURE John S. Connolly	

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12353

CERTIFICATE OF DEATH

12334

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 7 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena, Maryland				d. STREET ADDRESS 227 Arundel Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Annie Middle Elizabeth Last Smith				4. DATE OF DEATH Month November Day 25 Year 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 7, 1879	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min.		IF UNDER 24 HRS. Months 80 Days 80 Hours 80 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Unknown Henry Kornmann				14. MOTHER'S MAIDEN NAME Unknown Emma Sweitzer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral and generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 24 , 19 59 , to November 25 , 19 59 , that I last saw the deceased alive on Nov. 25 , 19 59 , and that death occurred at 1:45p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 11-25-59 ACTUAL SIGNATURE A. Simopoulos M.D. SPRING GROVE STATE HOSPITAL PHYSICIAN'S NAME (Type) Aristide Simopoulos, M. D. Catonsville 8, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/28/59		22c. NAME OF CEMETERY OR CREMATORY Baltimore cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Sander & Sons Inc.				24a. REC'D BY REGISTRAR DATE NOV 30 '59		24b. REGISTRAR'S SIGNATURE Calvin E. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Death certificate of [Name] [Address] [City] [State] [Date of Death] [Cause of Death] [Signature of Registrar] [Seal of Registrar]

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CERTIFICATE OF DEATH

12345

STATE OF NEW YORK DEPARTMENT OF HEALTH - BATHING, 18

<p>1. NAME OF DECEASED [Name]</p>		<p>2. SEX [Male/Female]</p>		<p>3. AGE [Age]</p>		<p>4. RACE [Race]</p>		<p>5. OCCUPATION [Occupation]</p>		<p>6. PLACE OF BIRTH [Place of Birth]</p>		<p>7. PLACE OF DEATH [Place of Death]</p>	
<p>8. DATE OF DEATH [Date]</p>		<p>9. TIME OF DEATH [Time]</p>		<p>10. CAUSE OF DEATH [Cause of Death]</p>		<p>11. MANNER OF DEATH [Manner of Death]</p>		<p>12. SIGNATURE OF REGISTRAR [Signature]</p>		<p>13. SEAL OF REGISTRAR [Seal]</p>		<p>14. OTHER NOTES [Notes]</p>	

X 1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12336

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Halethorpe c. LENGTH OF STAY IN lb MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4115 Washington Blvd., Trailer Camp				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 5605 Haddon Ave., Apt. B			
3. NAME OF DECEASED (Type or print) HENRY SMITH				4. DATE OF DEATH Month November Day 11 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-13-1916	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months 4 Days 4		IF UNDER 24 HRS. Hours 4 Min. 4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer		10b. KIND OF BUSINESS OR INDUSTRY Salvage		11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis				14. MOTHER'S MAIDEN NAME Sarah			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give number or dates of service)		17. INFORMANT Mary Smith - Same Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D.		DATE SIGNED 11/12/59	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11-13-59		22c. NAME OF CEMETERY OR CREMATORY Herring Run		22d. LOCATION (City, town, or country) (State) Balto Md	
23. FUNERAL DIRECTOR Jack Lewison ADDRESS 2100 Lutan Pl				24a. REC'D BY REGISTRAR NOV 13 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12335

12354

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY a.a.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 43 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY HARRIS SMITH Sr. (Served as: HARRY HARRIS SMITH)		4. DATE OF DEATH Month NOVEMBER Day 14 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-7-1900
9. AGE (In years lost birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 59 Days 14 Hours 19 Min. 59	11. IF UNDER 24 HRS. Months 59 Days 14 Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESSMAN		10b. KIND OF BUSINESS OR INDUSTRY NEWSPAPER	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry H. SMITH		14. MOTHER'S MAIDEN NAME Margaret J. White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-1 213-03-2401	
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMATEMESIS 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ESOPHAGEAL VARICIES DUE TO (c) CIRRHOSIS OF THE LIVER			
INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 2 , 19 59 , to November 14 , 19 59 , that I am the deceased's physician , and that death occurred at 3:55 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO 18, MD. FT. HOWARD DIV. DATE SIGNED 11/15/59			
ACTUAL SIGNATURE Paul Bormel		PHYSICIAN'S NAME (Type) PAUL BORMEL, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/18/59	
22c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEMORIAL PARK		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Wm J Tickner & Sons Inc North & Pennsylvania Aves Baltimore Md.		24a. REC'D BY REGISTRAR NOV 16 '59	
24b. REGISTRAR'S SIGNATURE William J. K...			

CERTIFICATE OF DEATH

12304

DATE OF DEATH

1942

PLACE OF DEATH

NEW YORK

CAUSE OF DEATH

HEART DISEASE

AGE AT DEATH

65

SEX

MALE

EDUCATION

HIGH SCHOOL

DATE OF BIRTH

1877

1942

PLACE OF BIRTH

NEW YORK

DATE OF DEATH

1942

PLACE OF DEATH

NEW YORK

CAUSE OF DEATH

HEART DISEASE

AGE AT DEATH

65

SEX

MALE

EDUCATION

HIGH SCHOOL

DATE OF BIRTH

1877

1942

PLACE OF BIRTH

NEW YORK

DATE OF DEATH

1942

PLACE OF DEATH

NEW YORK

CAUSE OF DEATH

HEART DISEASE

AGE AT DEATH

65

SEX

MALE

EDUCATION

HIGH SCHOOL

DATE OF BIRTH

1877

1942

PLACE OF BIRTH

NEW YORK

DATE OF DEATH

1942

PLACE OF DEATH

NEW YORK

CAUSE OF DEATH

HEART DISEASE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12355

CERTIFICATE OF DEATH

12337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland c. LENGTH OF STAY IN 1b 2 MONTHS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro, Maryland d. STREET ADDRESS Route 2 - Box 178 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Norvel Robert Smith		4. DATE OF DEATH Month 11 Day 20 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/26/58
9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR Months 8 Days 16	11. IF UNDER 24 HRS. Hours 16 Min. X-2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Robert Smith		14. MOTHER'S MAIDEN NAME Rose Marie Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
INFORMANT Rosewood Records		Address ---	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonitis 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) --- DUE TO (c) --- DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Meningitis in Oct. 1959; Hydrocephalus congenital		INTERVAL BETWEEN ONSET AND DEATH 48 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. ---		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-16- , 19 59 , to 11-20 , 19 59 that I last saw the deceased alive on 11-19 , 19 59 , and that death occurred at 4:15A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Viola B. Johns		ADDRESS (Street, city or town, state) Rosewood State Training School DATE 11/20/59	
PHYSICIAN'S NAME (Type) Viola B. Johns, M.D.		Owings Mills, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-22-59	
22c. NAME OF CEMETERY OR CREMATORY Brookes Cem.		22d. LOCATION (City, town, or county) (State) Knotttingham Md	
23. FUNERAL DIRECTOR'S SIGNATURE George S. Nelson		24a. REC'D BY REGISTRAR Arthur L. Evans	
ADDRESS 3484 Calhoun St		DATE NOV 24 '59	

CERTIFICATE OF DEATH

1935

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1935

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12356

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Overlea				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Overlea			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6802 Beech Avenue				d. STREET ADDRESS 6802 Beech Ave. Balto. 6, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Cecelia Snyder				4. DATE OF DEATH Month Day Year 11 26 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/19/1880		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Snyder				14. MOTHER'S MAIDEN NAME Mary Tremper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		INFORMANT Address Emma Dresch 6802 Beech Avenue #6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334x Cerebral arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) syn DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from oct 24 1959 , to nov 26 1959 , that I last saw the deceased alive on nov 24 1959 , and that death occurred at 10:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 111. OVERLEA AVE BALTO 6 Md							
ACTUAL SIGNATURE DR. RIGLER				M.D.			
PHYSICIAN'S NAME (Type) DR. RIGLER				BALTO 6 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/28/59		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Balto. City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Funeral Home 7401 Belair Rd				24a. REC'D BY REGISTRAR DATE DEC 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knap	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

17330



1000 000 000

1000 000 000

BALANCE

1000 000 000

1000 000 000

1000 000 000

12339

12357

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto.,				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Joppa Road				d. STREET ADDRESS 26 E. Joppa Rd.			
3. NAME OF DECEASED (Type or print) First Joseph Middle Snyder Last Snyder				4. DATE OF DEATH Month November Day 11 Year 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-71		9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months 88	IF UNDER 24 HRS. Days 88 Hours 88 Min. 88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Snyder				14. MOTHER'S MAIDEN NAME Mary Tremper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-40-0390		17. INFORMANT Catheri ne Snyder		Address 26 E. Joppa Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerosis, generalized DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.	Month 19	Day 19	Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Balto., Md.	(County) (State)
21. I certify that I attended the deceased from November 7 19 59 to November 11 19 59 that I last saw the deceased alive on November 10 19 59 and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Perry Hall Medical Group							
ACTUAL SIGNATURE Theodore E. Evans M.D.				PHYSICIAN'S NAME (Type) Theodore E. Evans			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-14-59		22c. NAME OF CEMETERY OR CREMATORY St. Joseph Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassam J. Jones				24a. REC'D BY REGISTRAR DATE NOV 16 59		24b. REGISTRAR'S SIGNATURE Charles E. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12340

Reg. Dist. No.

12358

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXX <u>Baltimore</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Martin Co.</u>				d. STREET ADDRESS <u>1219 Glenwood Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>7.</u> Last <u>Spear</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>19 59</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-5-1910</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Airplane</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Samuel W. Spear</u>				14. MOTHER'S MAIDEN NAME <u>Daisey Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Elizabeth A. Spear</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M.B. Davis</u> EXAMINER'S NAME (Type) <u>M.B. DAVIS MD</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>11/16/59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11-28-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Rd</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Christina S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. RACE <i>White</i>		5. BIRTH DATE <i>1925</i>		6. BIRTH PLACE <i>MD</i>	
7. DECEASED DATE <i>1970</i>		8. DECEASED TIME <i>10:00 AM</i>		9. DECEASED PLACE <i>Home</i>	
10. DECEASED CAUSE <i>Heart Disease</i>		11. DECEASED MANNER <i>Natural</i>		12. DECEASED SITE <i>Home</i>	
13. DECEASED OCCASION <i>Normal</i>		14. DECEASED DURATION <i>10 years</i>		15. DECEASED PERIOD <i>10 years</i>	
16. DECEASED PERIOD <i>10 years</i>		17. DECEASED PERIOD <i>10 years</i>		18. DECEASED PERIOD <i>10 years</i>	
19. DECEASED PERIOD <i>10 years</i>		20. DECEASED PERIOD <i>10 years</i>		21. DECEASED PERIOD <i>10 years</i>	
22. DECEASED PERIOD <i>10 years</i>		23. DECEASED PERIOD <i>10 years</i>		24. DECEASED PERIOD <i>10 years</i>	
25. DECEASED PERIOD <i>10 years</i>		26. DECEASED PERIOD <i>10 years</i>		27. DECEASED PERIOD <i>10 years</i>	
28. DECEASED PERIOD <i>10 years</i>		29. DECEASED PERIOD <i>10 years</i>		30. DECEASED PERIOD <i>10 years</i>	
31. DECEASED PERIOD <i>10 years</i>		32. DECEASED PERIOD <i>10 years</i>		33. DECEASED PERIOD <i>10 years</i>	
34. DECEASED PERIOD <i>10 years</i>		35. DECEASED PERIOD <i>10 years</i>		36. DECEASED PERIOD <i>10 years</i>	
37. DECEASED PERIOD <i>10 years</i>		38. DECEASED PERIOD <i>10 years</i>		39. DECEASED PERIOD <i>10 years</i>	
40. DECEASED PERIOD <i>10 years</i>		41. DECEASED PERIOD <i>10 years</i>		42. DECEASED PERIOD <i>10 years</i>	
43. DECEASED PERIOD <i>10 years</i>		44. DECEASED PERIOD <i>10 years</i>		45. DECEASED PERIOD <i>10 years</i>	
46. DECEASED PERIOD <i>10 years</i>		47. DECEASED PERIOD <i>10 years</i>		48. DECEASED PERIOD <i>10 years</i>	
49. DECEASED PERIOD <i>10 years</i>		50. DECEASED PERIOD <i>10 years</i>		51. DECEASED PERIOD <i>10 years</i>	
52. DECEASED PERIOD <i>10 years</i>		53. DECEASED PERIOD <i>10 years</i>		54. DECEASED PERIOD <i>10 years</i>	
55. DECEASED PERIOD <i>10 years</i>		56. DECEASED PERIOD <i>10 years</i>		57. DECEASED PERIOD <i>10 years</i>	
58. DECEASED PERIOD <i>10 years</i>		59. DECEASED PERIOD <i>10 years</i>		60. DECEASED PERIOD <i>10 years</i>	
61. DECEASED PERIOD <i>10 years</i>		62. DECEASED PERIOD <i>10 years</i>		63. DECEASED PERIOD <i>10 years</i>	
64. DECEASED PERIOD <i>10 years</i>		65. DECEASED PERIOD <i>10 years</i>		66. DECEASED PERIOD <i>10 years</i>	
67. DECEASED PERIOD <i>10 years</i>		68. DECEASED PERIOD <i>10 years</i>		69. DECEASED PERIOD <i>10 years</i>	
70. DECEASED PERIOD <i>10 years</i>		71. DECEASED PERIOD <i>10 years</i>		72. DECEASED PERIOD <i>10 years</i>	
73. DECEASED PERIOD <i>10 years</i>		74. DECEASED PERIOD <i>10 years</i>		75. DECEASED PERIOD <i>10 years</i>	
76. DECEASED PERIOD <i>10 years</i>		77. DECEASED PERIOD <i>10 years</i>		78. DECEASED PERIOD <i>10 years</i>	
79. DECEASED PERIOD <i>10 years</i>		80. DECEASED PERIOD <i>10 years</i>		81. DECEASED PERIOD <i>10 years</i>	
82. DECEASED PERIOD <i>10 years</i>		83. DECEASED PERIOD <i>10 years</i>		84. DECEASED PERIOD <i>10 years</i>	
85. DECEASED PERIOD <i>10 years</i>		86. DECEASED PERIOD <i>10 years</i>		87. DECEASED PERIOD <i>10 years</i>	
88. DECEASED PERIOD <i>10 years</i>		89. DECEASED PERIOD <i>10 years</i>		90. DECEASED PERIOD <i>10 years</i>	
91. DECEASED PERIOD <i>10 years</i>		92. DECEASED PERIOD <i>10 years</i>		93. DECEASED PERIOD <i>10 years</i>	
94. DECEASED PERIOD <i>10 years</i>		95. DECEASED PERIOD <i>10 years</i>		96. DECEASED PERIOD <i>10 years</i>	
97. DECEASED PERIOD <i>10 years</i>		98. DECEASED PERIOD <i>10 years</i>		99. DECEASED PERIOD <i>10 years</i>	
100. DECEASED PERIOD <i>10 years</i>		101. DECEASED PERIOD <i>10 years</i>		102. DECEASED PERIOD <i>10 years</i>	



Vertical text on the right margin, likely containing filing or administrative information.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12202 CERTIFICATE OF DEATH

Reg. Dist. No.

12341

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 56 S. Dundalk Ave.		d. STREET ADDRESS 56 S. Dundalk Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CONRAD Middle J. Last STEINBACH		4. DATE OF DEATH Month November Day 22 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 13, 1891
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist-Ret.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ferdinand Steinbach		14. MOTHER'S MAIDEN NAME Louise Brettschneider	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Sal y Steinbach, 56 S. Dundalk Ave-22		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 526x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic bronchiectasis DUE TO (c) Lung abscess.		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 8 months 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 19 59 , to NOV. 22 , 19 59 , that I last saw the deceased alive on NOV. 21 , 19 59 , and that death occurred at 11:30 P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 33 Dundalk Ave		DATE SIGNED David H. Andrew	
ACTUAL SIGNATURE David H. Andrew		M.D. Dundalk Md.	
PHYSICIAN'S NAME (Type) David H. Andrew			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/26/59	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Colgate, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.		24. REC'D BY REGISTRAR DATE NOV 27 59	
24b. REGISTRAR'S SIGNATURE William S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SOSS

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12359 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12342

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7309 Waldman Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest d. STREET ADDRESS 7309 Waldman Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNA First S. Middle STEPHENS Last 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH November 8, 19 59 Month November Day 8 Year 19 59 9. AGE (in years last birthday) 65 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Penna 11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME John Walters		14. MOTHER'S MAIDEN NAME Johannah ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mrs. Wm. H. Dawson 7309 Waldman Ave-19	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO A-S-C-V-Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/8/59	
EXAMINER'S NAME (Type) M. B. Davis M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/11/59	
22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Johnstown, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Avenue		24a. REC'D BY REGISTRAR NOV 10 '59 DATE 24b. REGISTRAR'S SIGNATURE Arthur E. Howard	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12360

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 090 Ridgeway Manor		d. STREET ADDRESS 15 Glenwood Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PHILIPPINA STEVERNAGEL First Middle Last		4. DATE OF DEATH Nov. 17 1959 Month Day Year	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/25/74
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker housewife		10b. KIND OF BUSINESS OR INDUSTRY Ind.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Reibert		14. MOTHER'S MAIDEN NAME Martha Dittman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. George Stevernagel	
17. INFORMANT Address George Stevernagel			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) ARTERIO SCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 8-12-59	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-12-1959 to Nov. 15, 1959 , that I last saw the deceased alive on Nov. 15, 1959 , and that death occurred at 11:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Carl Proetling M.D.		ADDRESS (Street, city or town, state) 1326 W. LOVIBARD ST DATE SIGNED Nov. 18, 1959	
PHYSICIAN'S NAME (Type) CARL PROETLING, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/21/59	22c. NAME OF CEMETERY OR CREMATORY London Park	22d. LOCATION (City, town, or county) (State) Balto. Md
23. FUNERAL DIRECTOR'S SIGNATURE Dr. McComb + Son ADDRESS 28		24a. REC'D BY REGISTRAR NOV 23 '59 24b. REGISTRAR'S SIGNATURE Charles S. Kline	

12344

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

12361

M

Form with multiple fields for death certificate, including sections for: Cause of Death, Place of Death, Date of Death, and Registrar's Office. The form is partially filled out with handwritten and typed information.

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

REGISTRAR'S OFFICE

Vertical text on the right margin, likely a filing or processing stamp, containing the words "RECEIVED" and "FILED".

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12345

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> 12362 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowleys Quarters, Md.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>242 Bay Drive</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowleys Quarters, Md.</u> d. STREET ADDRESS <u>242 Bay Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>Medford Getz Talbott</u>				4. DATE OF DEATH Month Day Year <u>Nov. 21, 1959</u>											
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-29-1894</u>		9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manufact. Rep.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charles Talbott</u>				14. MOTHER'S M maiden NAME <u>Margaret Getz</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-05-6349</u>				17. INFORMANT <u>Julia I. Talbott</u> Address <u>same</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>A-S-C-V-Disease</u> (c), stating the underlying cause lost. DUE TO												INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>											
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <u>M.B. Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>11/23/59</u>							
EXAMINER'S NAME (Type) <u>M.B. DAVIS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>11/25/59</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>								ADDRESS <u>5305 Harford Rd</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO DEPUTY MEDICAL EXAMINER: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

12363

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City 13X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Convalescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM E. TALBOTT				4. DATE OF DEATH Month Day Year Nov. 22, 1959 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1883		9. AGE (In years last birthday) yrs. 76	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Monrovia, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George E. Talbott				14. MOTHER'S MAIDEN NAME Georgia Gaither			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-34-3027		INFORMANT Mrs. Lenore Talbott, Clarksville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arterio Sclerosis (c) Hypocalcemia							INTERVAL BETWEEN ONSET AND DEATH 1 hr upon Smells
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov-1, 1959 to Nov-22, 1959 , that I last saw the deceased alive on Nov-20, 1959 , and that death occurred at 5:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Sutton Ave. Bk. 38 DATE SIGNED ACTUAL SIGNATURE Wetherbee Fort M.D. PHYSICIAN'S NAME (Type) Wetherbee Fort							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-25-59		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE NOV 27 '59		24b. REGISTRAR'S SIGNATURE Wm. S. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12845

MASSACHUSETTS STATE ARCHIVES - DEPT. OF READING

CERTIFICATE OF DEATH

12863

1

Full Name: William E. Talbot

Place of Birth: New York City

Shady Brook Convalescent Home

William E. Talbot

Age: 70

Married

George E. Talbot

710-21-307

1

11-21-30

Reading, Massachusetts

12364

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <i>Dr. Benjamin Tappan Sr.</i>			2. DATE OF DEATH <i>11/30/59</i> ✓		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>6904 Bellona Ave</i>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>BALTIMORE</i>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>BALTIMORE COUNTY</i> <i>6904 Bellona Ave</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>X</i> <i>Baltimore</i>		
c. Length of stay in Baltimore <i>55 yrs</i>			D. STREET ADDRESS (If rural, give location) <i>1 6904 Bellona Ave.</i>		
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>M.</i>	8. DATE OF BIRTH <i>March 9, 1890</i>	9. AGE (In years last birthday) <i>69</i>	10 Under 1 Year Months: Days 11 Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Physician</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Medical</i>		11. BIRTHPLACE (State or foreign country) <i>Rochester, N. Y.</i>	
13. FATHER'S NAME <i>William Tappan</i>			14. MOTHER'S MAIDEN NAME <i>Sarah E. Buchanan</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT ADDRESS <i>Balt, 12</i> <i>Mrs Edna Keyser Tappan 6904 Bellona Ave</i>	

18. <i>334x</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH (A) <i>Pharyngeal</i> DUE TO (B) <i>Rebilly</i> DUE TO <i>Cerebral arteriosclerosis</i> (C) <i>—</i>	INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i> <i>2 yrs</i> <i>1 yr</i>
--	--	--

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Coronary atherosclerosis</i>			
IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II	19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>

OF INJURY	WHILE AT WORK <input type="checkbox"/>	NOT WHILE AT WORK <input type="checkbox"/>
22. I certify that (I) (this hospital) attended the deceased from <i>11-20</i> to <i>11-29</i> and that death occurred at <i>3:00</i> p. m., from the causes and on the date stated above.		

23A. SIGNATURE <i>William D. Felt</i>	23B. ADDRESS <i>56 University Maryland</i>	23C. DATE SIGNED <i>12-1-59</i>
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	24B. DATE <i>12/2/59</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 2 1959</i>	REGISTRAR'S SIGNATURE <i>William D. Felt</i>	24C. NAME OF CEMETERY OR CREMATORY <i>London Park</i>
25. FUNERAL DIRECTOR <i>Loring Byers</i>		24D. LOCATION (City, town, or county) (State) <i>Balt. Md</i>

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Items 18-21, Film 252
252
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12348

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall 14X-2			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Fort Howard Hospital				d. STREET ADDRESS 14X-2			
3. NAME OF DECEASED (Type or print) First JOHN Middle C. Last THOMPSON				4. DATE OF DEATH Month November Day 8, Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14 - 1924	9. AGE (In years last birthday) 35 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jewell Thompson				14. MOTHER'S MAIDEN NAME EDITH WARNER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W. # 2		16. SOCIAL SECURITY NO.		17. INFORMANT Address MRS. THOMPSON: Rock Hall Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 819X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Brain trauma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Passenger of auto into fixed object					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10/26/59 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) Rock Hall	(County) Kent	(State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Russell S. Fisher		M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/9/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Nov. 11	22c. NAME OF CEMETERY OR CREMATORY Wesley CHAPEL	22d. LOCATION (City, town, or country) Rock Hall	(State) Md.			
23. FUNERAL DIRECTOR Edgar L. Lane: Church Hill, Ind.		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 13 '59	24b. REGISTRAR'S SIGNATURE C. S. Kinn		

12345

12345

Wm. J. Harrison took from Mr.
Edith W. Harrison
Married

Yes W. J. Harrison
Edith W. Harrison
Married

Wm. J. Harrison took from Mr.
Edith W. Harrison
Married

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12349

CERTIFICATE OF DEATH

12366

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u>		LENGTH OF STAY (in this place) <u>22 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Reisterstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Thompson Avenue</u>				STREET ADDRESS (If rural give location) <u>Thompson Avenue</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Arthur Leonard Tinkler</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>November 2 19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>August 5 1882</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm manager</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Tinkler</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Wornell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-03-3736</u>		17. INFORMANT & ADDRESS <u>Arthur O Tinkler Reisterstown Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>hypertension & arteriosclerosis</u>				<u>years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Coronary Thrombosis</u>				<u>1958</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-1-40</u> to <u>11-3-59</u> , that I last saw the deceased alive on <u>11-3-59</u> , and that death occurred at <u>11:00 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James H. Saffell</u>				DATE SIGNED <u>Reisterstown Md 11-4-59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov 5 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Reisterstown Md</u>	
24. REC'D BY REGISTRAR DATE <u>NOV 5 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Brynman + Sons</u> ADDRESS <u>Reisterstown</u>			

CERTIFICATE OF DEATH

1938

REG. DIST. NO.

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ENCLOSURES

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12350

12203

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MD. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 DUNDALK d. STREET ADDRESS 204 Chestnut St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First John Middle Caleb Last Toye				4. DATE OF DEATH Month Nov Day 28 Year 1959															
5. SEX M		6. COLOR OR RACE Col		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 14, 1918		9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Steel plant				11. BIRTHPLACE (State or foreign country) Calvert Co. Md.				12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Edward Toyne						14. MOTHER'S MAIDEN NAME Katie Gorman													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Ann Toyne Nolley 612 Pitcher Street													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic heart disease, with aortic and mitral stenosis and regurgitation. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)												INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>W. Bradley King</i>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED Nov. 29, 1959							
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										22b. DATE THEREOF 12/3/59		22c. NAME OF CEMETERY OR CREMATORY Bald. Park		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Frank</i>						ADDRESS 7031 Avenue Hill Ave.				24a. REC'D BY REGISTRAR NOV 30 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

CERTIFICATE OF DEATH

Reg. Dist. No.

12367

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in Pines, 16 Fusting Ave		d. STREET ADDRESS 23 S. Wickham Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle R. Last Valentine		4. DATE OF DEATH Month Nov. Day 16 , Year 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1887
9. AGE (In years less birthday) yrs. 72		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY Johns Hopkins University	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. J. Valentine		14. MOTHER'S MAIDEN NAME Ella Stitely	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213 03 0240	
INFORMANT Mrs. Jeannette Valentine		Address 23 S. Wickham Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS GENERALIZED 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA ASCENDING COLON DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 YEAR 1 1/2 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ANEMIA PROFOUND		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN. 3 , 19 57 , to NOV. 16 , 19 59 , that I last saw the deceased alive on NOV. 16 , 19 59 , and that death occurred at 11:25 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John F. Schaefer		ADDRESS (Street, city or town, state) DATE SIGNED 401 RANDOM ROAD BARTO. 29 MD. 11/18/59	
PHYSICIAN'S NAME (Type) JOHN F. SCHAEFER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 19/59	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edmondson Ave.		24a. REC'D BY REGISTRAR DATE NOV 19 59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. K...</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

DATE OF DEATH

DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G253 12-14-59 et

CERTIFICATE OF DEATH

12368

Reg. Dist. No.

12352

1. PLACE OF DEATH a. COUNTY BALTIMORE Baltimore MD. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton 4,				c. LENGTH OF STAY IN 1b 79yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1510 MAYWOOD AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle AURTHUR Last VAN HORN				4. DATE OF DEATH Month NOV. Day 21, Year SAT. 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-21-1882		9. AGE (In years lost birthday) 77 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STONE MASON		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) RIDERWOOD MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJEMIN VAN HORN				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-05-5251		17. INFORMANT WILLIAM B. STONE Address GREENGLADE RD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 5 , 19 59 , to Nov 21 , 19 59 , that I last saw the deceased alive on Nov 21 , 19 59 , and that death occurred at 1 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 East Biddle Street DATE SIGNED 11/23/59							
ACTUAL SIGNATURE F. M. Dugan		PHYSICIAN'S NAME (Type) F. M. Dugan, M.D. Baltimore 2, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Type)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		11-24-59		PROSPECT HILL		TOWSON MD.	
23. FUNERAL DIRECTOR'S SIGNATURE BROOKS FUNERAL SER. 622 YORK RD.				24a. REC'D BY REGISTRAR DATE NOV 25 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

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UNITED STATES OF AMERICA

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Baltimore, Maryland

MD

Baltimore, Maryland

RIDGE H.

1928.

RIDGE H.

1510 WOODWARD AVE.

1510 WOODWARD AVE.

ARTHUR VAN HORN, JR.

WILLIAM

2-21-1898

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WILSON, WILLIAM E. STONE

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12369 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12353

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh		c. LENGTH OF STAY IN 1b X White Marsh	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ebenezer Rd.		d. STREET ADDRESS Ebenezer Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Helen M. Vincent		4. DATE OF DEATH Nov. 27, 19 59	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1894	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Dougherty		14. MOTHER'S MAIDEN NAME Julia Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Ida Gray		Address Ebenezer Rd. White Marsh, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M. B. Davis M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11/30/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-1-1959	
22c. NAME OF CEMETERY OR CREMATORY St. Joseph's		22d. LOCATION (City, town, or county) (State) Fullerton, Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lorraine J. Hone		ADDRESS Home 7401 Belair Rd.	
24a. REC'D BY REGISTRAR DEC 2 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hone	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES H. HARRIS		45		M		W		10-1-20	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1000 N. E. ST.		LABORER		HEART DISEASE		NATURAL		HOME	
CITY		COUNTY		STATE		FEDERAL DISTRICT		COUNTRY	
BALTIMORE		BALTIMORE		MARYLAND		DISTRICT OF COLUMBIA		UNITED STATES	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		NAME OF EXAMINER		SIGNATURE OF EXAMINER	
10-1-20		10:00 AM		HOME		J. H. HARRIS		[Signature]	
DATE OF BURIAL		TIME OF BURIAL		PLACE OF BURIAL		NAME OF BURIAL PLACE		SIGNATURE OF BURIAL PLACE	
10-1-20		10:00 AM		HOME		J. H. HARRIS		[Signature]	
DATE OF INTERMENT		TIME OF INTERMENT		PLACE OF INTERMENT		NAME OF INTERMENT PLACE		SIGNATURE OF INTERMENT PLACE	
10-1-20		10:00 AM		HOME		J. H. HARRIS		[Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12370

Item 12 Film G252 11-30-59 et

CERTIFICATE OF DEATH

12354

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co. 21. Md. MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN 1b <u>54 Essex</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>703 Christian Avenue</u>		d. STREET ADDRESS <u>703 Christian Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Adolph</u> Middle <u>J.</u> Last <u>Waitkus</u>		4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mill-wright - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Eastern Stain. Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-10-7793</u>	
17. INFORMANT <u>Mrs. Mary Scharmer</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X</u> DUE TO <u>Circulatory failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia, lobar</u> (c) <u>Cancer of the lung</u> <u>Emphysema thoracis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 days</u> <u>3 days</u> <u>4 weeks final</u> <u>2 months.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema thoracis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-16</u> 19 <u>59</u> to <u>11-21</u> 19 <u>59</u> , that I last saw the deceased alive on <u>11-20</u> 19 <u>59</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eugene C. Baumann</u>		ADDRESS (Street, city or town, state) <u>413 EASTERN AVE. ESSEX, Md</u>	
PHYSICIAN'S NAME (Type) <u>Eugene C. Baumann</u>		DATE SIGNED <u>11/21/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-24-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Christine Brydzinski</u>		ADDRESS <u>1407 Eastern Ave (21)</u>	
24a. REC'D BY REGISTRAR <u>NOV 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>	

CERTIFICATE OF DEATH

1937

AVAILABILITY

IN THE

DEPARTMENT OF HEALTH

STATE OF MARYLAND

DEPARTMENT OF HEALTH

STATE OF MARYLAND

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12355

12371

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>52</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>5 Paradise Avenue</i>		d. STREET ADDRESS <i>5 Paradise Ave</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mr Thomas</i> First <i>Leonard</i> Middle <i>Walter</i> Last		4. DATE OF DEATH Month <i>November</i> Day <i>9th</i> Year <i>19 59</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 22, 1886</i> 9. AGE (In years last birthday) <i>73</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Eng. General Motors</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i> 11. BIRTHPLACE (State or foreign country) <i>USA</i>	
13. FATHER'S NAME <i>Charles C. Walter</i>		14. MOTHER'S MAIDEN NAME <i>Harriet A. Poulton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>216-01-7628</i>		17. INFORMANT Address <i>B Mrs. Alice Grimm 2902 Onyx Rd. Balto.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> <i>177x</i> DUE TO <i>Carcinoma of the Prostate</i> Conditions, if any, which gave rise to immediate cause (b) <i>Transurethral prostatectomy performed in October 1959</i> (c) <i>Transurethral prostatectomy performed in October 1959</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Transurethral prostatectomy performed in October 1959</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Geo. S. M. Kieffer</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Geo. S. M. Kieffer M.D.</i>		DATE SIGNED <i>Nov. 9, 1959</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/12/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Leonard J. Ruck 5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 13 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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Colombia

Colombia

1901

WINTER

1901

Colombia

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1901-1902

Reg. Dist. No. 12356

12372

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>6yr11mth18days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Melvin</u> <u>Ward</u>		4. DATE OF DEATH Month Day Year <u>November 24</u> <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15, 1905</u>
9. AGE (In years last birthday) yrs. <u>54</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frederick Ward</u>		14. MOTHER'S MAIDEN NAME <u>Cassie E. Heck</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra-abdominal and pulmonary metastasis</u> <u>153.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the transverse colon</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 4</u> , 19 <u>59</u> , to <u>Nov. 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 24</u> , 19 <u>59</u> , and that death occurred at <u>7:15p</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 11-25-59</u>	
PHYSICIAN'S NAME (Type) <u>Bruno Radauskas, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 27 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loar Creek Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Chestnut Hill Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Archer - Benoni - Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>NOV 27 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by you, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE, MD.
CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

1. NAME OF DECEASED MAYNARD		2. SEX M		3. AGE 40		4. RACE W		5. DATE OF BIRTH 1918		6. PLACE OF BIRTH BALTIMORE, MD.	
7. DATE OF DEATH 1958		8. TIME OF DEATH 10:00 AM		9. PLACE OF DEATH HOME		10. CAUSE OF DEATH HEART DISEASE		11. MANNER OF DEATH NATURAL		12. SIGNATURE OF PHYSICIAN J. H. SMITH	
13. SIGNATURE OF REGISTRAR J. H. SMITH		14. SIGNATURE OF WITNESS J. H. SMITH		15. SIGNATURE OF WITNESS J. H. SMITH		16. SIGNATURE OF WITNESS J. H. SMITH		17. SIGNATURE OF WITNESS J. H. SMITH		18. SIGNATURE OF WITNESS J. H. SMITH	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12373

CERTIFICATE OF DEATH

Reg. Dist. No.

12357

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WALTER Middle W Last WARD				4. DATE OF DEATH Month November Day 25 Year 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 19, 1920	
9. AGE (In years lost birthday) 39 yrs.		IF UNDER 1 YEAR Months 3 Days 01 Hours 04 Min.		IF UNDER 24 HRS. Hours 04 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SAND BLASTER				10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WALTER W. WARD				14. MOTHER'S MAIDEN NAME MOLLIE EISEL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-11				16. SOCIAL SECURITY NO. 213-12-2940			
INFORMANT CLIN REC VAH BALTIMORE MD FT HOWARD DIVISION				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GLIOMA OF THE LEFT TEMPORAL AND OCCIPITAL LOBES 193.0 INDEX OF BRAIN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) ENCEPHALOMALACIA; EDEMA OF LUNGS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ENCEPHALOMALACIA; EDEMA OF LUNGS							
INTERVAL BETWEEN ONSET AND DEATH 18 MONTHS							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that VA attended the deceased from November 24, 1959 to November 25, 1959 and that the deceased died on November 25, 1959 and that death occurred at 10:00 AM from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Clovis M. Snyder				M.D. VAH, Baltimore Md.-Ft Howard Div. 11-25-59			
PHYSICIAN'S NAME (Type) CLOVIS M. SNYDER				M.S. VAH, Baltimore Md - Ft Howard Div. 11-25-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-30-59		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WM COOK-BLIGHT INC				ADDRESS 6009 Harford Road Baltimore 14 Md		24a. REC'D BY REGISTRAR DEC 2 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kious	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12374

12358

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex 21</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Essex 21</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1021 B Eastern Ave</u>		d. STREET ADDRESS <u>1021 B Eastern Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Evelyn</u> First <u>Wasson</u> Middle <u>Wasson</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OF FACE <u>gt</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-27-14</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>5</u> Hours <u>15</u> Min. <u>00</u>	IF UNDER 24 HRS. Months <u>4</u> Days <u>5</u> Hours <u>15</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Va</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Carl Stallard</u>	
14. MOTHER'S MAIDEN NAME <u>Agnes William</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>James Wasson</u>		17. INFORMANT <u>same</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>422.1</u> DUE TO (c) <u>422.1</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchitis</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>11-10-59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-15</u> , 19 <u>58</u> , to <u>11-10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-10</u> , 19 <u>59</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>805 Fuselage Ave, Balto</u> DATE SIGNED <u>70261</u>	
ACTUAL SIGNATURE <u>M. A. Castro, Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>M. A. CASTRO, JR., M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-11-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bellevue Cemetery</u>		22d. LOCATION (City, town or county) (State) <u>Russell Co Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>1407 Eastern Ave.</u>		24a. REC'D BY REGISTRAR <u>NOV 12 59</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kroll</u>			

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12359

12375

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b <u>X Rural Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>E.</u> Last <u>Weber</u>		4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 9, 1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Masonry-Contractor Randallstown, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Weber</u>		14. MOTHER'S MAIDEN NAME <u>Mary Klohr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>219-10-6174</u>	
17. INFORMANT <u>Mrs. Florence Wever, Pikesville 8, Md.</u>		18. ADDRESS <u>Castleon Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>1957</u> to <u>Nov 6</u> , 19 <u>59</u> that I last saw the deceased alive on <u>Oct 30</u> , 19 <u>59</u> , and that death occurred at <u>5:30 P.</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Keisterstown Maryland Nov 8, 1959</u>	
ACTUAL SIGNATURE <u>Clarence E McWilliams</u> M.D.		DATE SIGNED <u>Nov 8, 1959</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 9, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville 8</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1935

1935

DEATH IN CITY OF NEW YORK

NEW YORK

NEW YORK

Blank form for Certificate of Death with horizontal lines for text entry.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12360

12211

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Highlands</u>		c. LENGTH OF STAY IN 1b <u>35 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. Highlands</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2926 Ohio Ave.</u>				d. STREET ADDRESS <u>2926 Ohio Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis B Weber</u> First Middle Last				4. DATE OF DEATH Month <u>Nov.</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 23. 1890</u>		9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tailor</u>		11. BIRTHPLACE (State or foreign country) <u>Harister Mich</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Thomas Weber</u>				14. MOTHER'S MAIDEN NAME <u>Manzano?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-32-9386</u>		17. INFORMANT <u>Mr. Agnes J. Weber</u> Address <u>2926 Ohio Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broken neck, Fractured vertebrae</u> <u>900.0</u> DUE TO <u>Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down cellar steps inside of cellar</u>					
20c. TIME OF INJURY <u>3:40 PM</u> Month, Day, Year <u>11-28-59</u> p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Balto. Highlands Balto. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S.M. Kieffer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Geo. S.M. Kieffer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George A. Weber</u>				ADDRESS <u>705 S. Chas St</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. S. Frank</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		TIME OF DEATH		PLACE OF BURIAL	
EDUCATION		RELIGION		MARITAL STATUS		SINGLE		MARRIED		WIDOWED	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO	
HISTORY OF PRESENT ILLNESS		SYMPTOMS		SIGNS		LABORATORY TESTS		X-RAY		PATHOLOGICAL FINDINGS	
MEDICAL HISTORY		FAMILY HISTORY		SOCIAL HISTORY		PSYCHOLOGICAL HISTORY		SUBSTANCE ABUSE		OTHER RELEVANT HISTORY	
PHYSICAL EXAMINATION		VITAL SIGNS		HEENT		HEART		LUNGS		GASTROINTESTINAL	
NEUROLOGICAL EXAMINATION		MUSCULOSKELETAL EXAMINATION		DERMATOLOGICAL EXAMINATION		LABORATORY TESTS		X-RAY		PATHOLOGICAL FINDINGS	
MORPHOLOGY		WEIGHT		HEIGHT		TEMPERATURE		PULSE		BLOOD PRESSURE	
LABORATORY TESTS		X-RAY		PATHOLOGICAL FINDINGS		TOXICOLOGY		IMMUNOLOGY		OTHER TESTS	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		CITY		STATE	

1

CERTIFICATE OF DEATH

Reg. Dist. No.

12376

12361

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 52 Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5900 Cecil Ave				d. STREET ADDRESS 5900 Cecil Ave			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Helen Middle A. Last Weil				4. DATE OF DEATH Month Nov. Day 19 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 19 1907	
9. AGE (In years last birthday) 52		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore Co. Md	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Robert H. Keith				14. MOTHER'S MAIDEN NAME Elizabeth Hood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs. Margaret Healey, Catonsville, Md				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion = Myocardial infarction 6 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO _____ (c) DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from Nov 14 , 19 59 , to Nov 19 , 19 59 , that I last saw the deceased alive on Nov 19 , 19 59 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above. ADDRESS (Street city or town state) 4001 Wilkens Avenue DATE SIGNED Nov 20 59							
ACTUAL SIGNATURE Earl Pass M.D.				PHYSICIAN'S NAME (Type) Earl Pass, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11-23-59			
22c. NAME OF CEMETERY OR CREMATORY Lorraine				22d. LOCATION (City, town, or county) (State) Woodlawn, Md			
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE NOV 23 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA

1937

Witness

Notary

Attorney

County, Ill.

State of Ill.

State of Ill.

Helen

A.

Well

Nov. 19

County, Ill.

At Home

Elizabeth Hood

Robert H. Nelson

Mrs. Margaret A. Nelson, County, Ill.

Ill.

Ill.

4001 Wilkins Avenue

Earl Pace, M. D.

Notary

12-21-37

F. C. Robinson, Illinois City, Ill.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12363

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3110 Cornwall Road</u>		d. STREET ADDRESS <u>107 S. Patomac Street</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret Mary</u> First <u>M.</u> Middle <u>Welsh</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 2, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kearin Coughlin</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Murdock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Miss Margaret Welsh</u>		Address <u>107 S. Potomac St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>stating the underlying cause lost.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Jack C. Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11-30-57</u>	
EXAMINER'S NAME (Type) <u>Jack C. Collins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u>		ADDRESS <u>3000 E. Baltimore Street</u>	
24a. REC'D BY REGISTRAR <u>DEC 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director or. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12378

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) IDEEWYLDE (BALTO. 12)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6311 BEECHWOOD ROAD				d. STREET ADDRESS 6311 BEECHWOOD ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELIZABETH WARWICK WHITNEY		First Middle Last		4. DATE OF DEATH NOVEMBER 11 19 59		Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 24, 1896	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME OTWAY WARWICK				14. MOTHER'S MAIDEN NAME ELIZABETH GORDON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. NONE		INFORMANT FAMILY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypernephroma, left 180 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> 19 <u>59</u> , to <u>Nov. 11</u> , 19 <u>59</u> that I last saw the deceased alive on <u>Nov. 7</u> , 19 <u>59</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE W. P. Benson, Jr.		ADDRESS (Street, city or town, state) DATE SIGNED 3506 N. Calvert St., Balto., Md. 11/12/59					
PHYSICIAN'S NAME (Type) W. P. BENSON, JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/13/59		22c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons		ADDRESS TOWSON MARYLAND		24a. REC'D BY REGISTRAR DATE NOV 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13318

CENTRAL BANK OF MARYLAND

BALTIMORE

MARYLAND

BALTIMORE

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CENTRAL BANK OF MARYLAND

11/13/11

WILMINGTON

MARYLAND

WILMINGTON

12379

CERTIFICATE OF DEATH

Reg. Dist. No. 12365

1. PLACE OF DEATH a. COUNTY BALTIMORE COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Md.				c. LENGTH OF STAY IN 1b July 14, 1959			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AGED WOMEN'S AND MEN'S HOME				d. STREET ADDRESS 2907 North Calvert St.			
3. NAME OF DECEASED (Type or print) Annie Dora Winters				4. DATE OF DEATH Nov. 19 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 6, 1880	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) Registered Nurse				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Fredrick C. Winters				14. MOTHER'S MAIDEN NAME Mary Oymal			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Probable myocardial infarction and pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic Cardiovascular DUE TO (c) heart disease; bacterial etiology unknown				INTERVAL BETWEEN ONSET AND DEATH Days years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov 19 , 19 59 , to Nov 19 , 19 59 , that I last saw the deceased alive on Nov 19 , 19 59 , and that death occurred at 11 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore 12, Md. DATE SIGNED Nov 20 1959							
ACTUAL SIGNATURE William H. Kirby, Jr. M.D.							
PHYSICIAN'S NAME (Type) William H. Kirby, Jr							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-21-59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR NOV 20 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1937

1937

[Faint, mostly illegible text from the reverse side of the document, including names and dates.]

CERTIFICATE OF DEATH

Reg. Dist. No.

12380

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Fullerton				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 312 Trumps Mill Road				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frederick C. Wolf				4. DATE OF DEATH Month Day Year 11 26 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/3/1877	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-Retired				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George M. Wolf				14. MOTHER'S MAIDEN NAME Frederick Vogt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-01-6865			
INFORMANT John Wolf				Address Box 312 Trumps Mill Rd. #6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral apoplexy 422.1 DUE TO arteriosclerotic Cardio-Vascular disease 2 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1 , 19 59 , to 11/26 , 19 59 that I last saw the deceased alive on Nov 25 , 19 59 , and that death occurred at 10A M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED G. M. Baumgardner Baltimore Md 11/27/59							
ACTUAL SIGNATURE G. M. Baumgardner							
PHYSICIAN'S NAME (Type) G. M. Baumgardner							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/30/59		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem		22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home				ADDRESS 7401 Belair Rd		24a. REC'D BY REGISTRAR DATE DEC 1 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or funeral home.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

15388

Final - Will signed

Box 215, Spring Hill, Tenn.

State of Tenn.

County of Davidson

Personal

Personal

Box 215, Spring Hill, Tenn.

Cardinal apoplexy

Interment in the Spring Hill, Tenn.

Interment in the Spring Hill, Tenn.

Interment in the Spring Hill, Tenn.

Interment in the Spring Hill, Tenn.

Interment in the Spring Hill, Tenn.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12367

12381

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland c. LENGTH OF STAY IN 1b 6 yrs, 4 mos. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30, Maryland d. STREET ADDRESS 1834 East Fayette Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ivan Middle Neal Last Woods, Jr.		4. DATE OF DEATH Month 11 Day 18 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/19/49
9. AGE (In years lost birthday) 10 yrs.		10. IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	11. IF UNDER 24 HRS. Months 10 Days 10 Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ivan Neal Woods		14. MOTHER'S MAIDEN NAME Norma Lee Stevens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Rosewood Records	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Grand mal seizure DUE TO (b) Epilepsy Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 2:00a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Pete W. Rieckert		ADDRESS (Street, city or town, state) 4307 Mainfield Rd Baltimore 14, Md	
PHYSICIAN'S NAME (Type) Pete W. Rieckert		DATE SIGNED 11/18/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-23-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Inc. Preston & St...		24a. REC'D BY REGISTRAR NOV 20 1959	
24b. REGISTRAR'S SIGNATURE Arthur S. Kram			

CERTIFICATE OF DEATH

1938

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is faint and mostly illegible.

Calling 8 Hours

VS. A1SME
5M 7/S9

DEATH CERTIFICATE

1900

Baltimore

Baltimore

Baltimore

Baltimore

Baltimore

6021 Haining Avenue

6021 Haining Avenue

November 2, 1900

1900

1900

1900

1900

1900

Special Agent
Detective Agency

Charles E. Kelly, Jr.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12382

Film G252-Items 10, 13, 14, 15, 16 -mb 11/20/59

Reg. Dist. No.

12369

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whitehall, Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE Hospital</u>		d. STREET ADDRESS <u>12X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>LESLIE</u> Middle <u>WRIGHT</u> Last <u>WRIGHT</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 31-1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN RICHARD WRIGHT</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN MARY ELLEN REED</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u> no		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Hospital's Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Cardiovascular disease</u> DUE TO (c) <u>disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>attempted suicide Sept 25 59 cut throat with razor blade</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>unable to repair damage. tracheostomy performed</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Still breathing tube</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>GEO. S. M. KIEFFER</u>		DATE SIGNED <u>Nov 15 59</u>	
EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 17, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arcea Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>White Hall Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Kuep</u>		24a. REC'D BY REGISTRAR <u>Nov 20 59</u>	
ADDRESS <u>Parrettsville Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

12383

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS Mills</u>		c. LENGTH OF STAY IN 1b <u>2 WKS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROSEWOOD STATE TRAINING SCHOOL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROTH</u> Middle <u>LUCILLE</u> Last <u>YEATER</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-27-16</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months <u>+</u> Days <u>+</u> Hours <u>+</u> Min. <u>+</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES WESLEY YEATER</u>		14. MOTHER'S MAIDEN NAME <u>MA DORVEY JAWSON YEATER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ROSEWOOD RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism com-</u> <u>465X</u> DUE TO <u>plicated by aspiration of</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>stomach content</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/3</u> , 19 <u>59</u> , to <u>11/14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/14</u> , 19 <u>59</u> , and that death occurred at <u>2:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter W. Rieckert</u> Pathologist M.D.		ADDRESS (Street, city or town, state) <u>4307 Main Rd Baltimore</u> DATE SIGNED <u>11-15-59</u>	
PHYSICIAN'S NAME (Type) <u>P. W. Rieckert</u>		<u>Baltimore</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-18-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lumberport Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Lumberport, W. Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers, Inc. Wash, D.C.</u> <u>by Jesse Brown</u>		24a. REC'D BY REGISTRAR <u>NOV 18 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

1

CERTIFICATE OF DEATH

Reg. Dist. No.

12371

12384

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>2mo. 7 days</u> x <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE Hospital</u>		d. STREET ADDRESS <u>6901 FAIR AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LEON</u> Middle <u>ZIEMSKI</u> Last <u>ZIEMSKI</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/25/17</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GROCER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN ZIEMSKI</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE DUMBROSKI</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>218325055</u>	
17. INFORMANT <u>RECORDS; SPRING GROVE Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nodular Cirrhosis of the liver</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-7</u> , 19 <u>59</u> , to <u>11-14-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-14</u> , 19 <u>59</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>José R. Arizaga M.D.</u> M.D.		<u>Spring Grove State Hosp. Nov. 15, 1959</u>	
PHYSICIAN'S NAME (Type) <u>JOSÉ R. ARIZAGA</u>		<u>Catonville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Mary</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. F. SADOWSKI & SONS</u>		ADDRESS <u>1808 EASTERN AVE</u>	
24a. REC'D BY REGISTRAR <u>NOV 17 '59</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

